MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

# Medicaid in Montana 2021

FOR MORE INFORMATION CONTACT DPHHS PIO JON EBELT AT JEBELT@MT.GOV OR CALL 406-444-0936.

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# Medicaid - Authorities

The Montana Medicaid Program is authorized under 53-6-101, Montana Code Annotated, and Article XII, Section XII of the Montana Constitution. The Department of Public Health and Human Services administers the program. Each state Medicaid program is a combination of state plan and waiver authorities, allowing each state to meet the unique needs of their citizens.

## State Plan

"The state plan is a formal, written agreement between a state and the federal government, submitted by the single state agency (42 CFR 431.10) and approved by CMS, describing how that state administers its Medicaid program.

The state plan:

- provides assurances that a state will abide by federal rules in order to claim federal matching funds;
- indicates which optional groups, services, or programs the state has chosen to cover or implement; and
- describes the state-specific standards to determine eligibility, methodologies for providers to be reimbursed, and processes to administer the program."

https://www.macpac.gov/subtopic/state-plan/

MACPAC Reference Guide to Federal Medicaid Statute and Regulations

https://www.macpac.gov/reference-guide-to-federal-medicaid-statute-and-regulations/

## Waivers

"States seeking additional flexibility can apply to the Secretary of HHS for formal waivers of certain statutory requirements. For example, states can request waivers of provisions requiring service comparability, statewideness, and freedom of choice in order to offer an alternative benefit plan to a subset of Medicaid beneficiaries, to restrict enrollees to a specific network of providers, or to extend coverage to groups beyond those defined in Medicaid law. In exchange for the flexibility offered by waivers, states must meet budgetary criteria and provide regular reports and evaluations to CMS to show that the requirements of the waiver are being met, which are not requirements placed on state plans. Also unlike most SPAs, waivers require lengthy applications and must be renewed periodically. A state can operate significant portions of its program under waiver authority but must maintain a complete and up-to-date state plan in order to access federal funds." https://www.macpac.gov/subtopic/state-plan/

## Medicaid – A State and Federal Partnership

The Medicaid program is jointly funded by the federal government and states. The federal government reimburses states for a specified percentage of allowable program expenditures depending on the expenditure type.

### FMAP

Federal Medicaid funding to states, called the Federal Medical Assistance Percentage (FMAP), is calculated by comparing personal income in each state with the national average.

**TABLE 1 - SERVICES FUNDING RATES**

| Services Funding (SFY 2021) | State Share | Federal Share |
|---|---|---|
| Indian & Tribal Health Services | | 100% |
| Medicaid Expansion | 10% | 90% |
| Family Planning Service | 10% | 90% |
| Money Follows the Person | 17% | 83% |
| Breast and Cervical Cancer Program | 24% | 76% |
| Community First Choice (FMAP +6%) | 29% | 71% |
| Standard FMAP | 35% | 65% |
| State Funded | 100% | |

**TABLE 2 - ADMINISTRATION FUNDING RATES**

| Administration Funding (SFY 2021) | State Share | Federal Share |
|---|---|---|
| Systems Development (if pre-approved) | 10% | 90% |
| Systems Development | 25% | 75% |
| Skilled Medical Personnel | 25% | 75% |
| Claims Processing Systems and Operations | 25% | 75% |
| Eligibility Determination Systems and Staffing | 25% | 75% |
| All Other Administration | 50% | 50% |

# Medicaid - Eligibility

Montana Medicaid provides coverage for the following groups/populations:

- Infants and Children
- Subsidized Adoptions, Subsidized Guardianship, and Foster Care
- Pregnant Women
- Low Income Families with Dependent Children
- Low Income Adults
- Low Income Adults with an SDMI
- Aged, Blind/Disabled and/or receiving Supplemental Security Income
- Breast and Cervical Cancer Treatment
- Montana Medicaid for Workers with Disabilities (MWD)
- Medically Needy

**More information is available at:**

Montana Healthcare Programs – Member Services

Offices of Public Assistance (OPA)

# Medicaid Eligibility – Infants and Children

**Newborn Coverage** – Children born to women receiving Medicaid (at the time of their child's birth) automatically qualify for Medicaid coverage through the month of their first birthday.

**Healthy Montana Kids Plus (HMK Plus)** – Provides medically necessary health care coverage for children through the month of their 19th birthday, in families with countable income up to 143% of the Federal Poverty Level (FPL). Montana Medicaid and HMK Plus pay for services that are:

- Provided by a Montana Medicaid/HMK Plus enrolled provider
- Within the scope of listed Medicaid/HMK Plus covered services

**Subsidized Adoption, Subsidized Guardianship and Foster Care** – Children eligible for an adoption or guardianship subsidy through DPHHS automatically qualify for Medicaid coverage. Coverage may continue through the month of the child's 26th birthday. Children placed into licensed foster care homes by the Child and Family Services Division are also Medicaid eligible.

**TABLE 3 – 2019 FEDERAL POVERTY LEVELS AND GROSS MONTHLY INCOME**

| Family Size | Pregnant Women 157% FPL | HMK 261% FPL | Child or HMK Plus 143% FPL |
|---|---|---|---|
| 1 | $1,634 | $2,717 | $1,488 |
| 2 | $2,212 | $3,678 | $2,015 |
| 3 | $2,791 | $4,639 | $2542 |
| 4 | $3,369 | $5,601 | $3,069 |
| Resource Test | No Test | No Test | No Test |

# Medicaid Eligibility – Low Income Montanans

**Low Income Families – Standard Medicaid**
Adult members of Montana families whose household countable income equal is less than 25% FPL are eligible for standard Medicaid.

**Low Income Families – Expansion Medicaid**
Adult members of Montana families whose household countable income equal is between than 25% and 138% FPL are eligible for Medicaid Expansion.

**Low Income Montanans – Expansion Medicaid**
Montana families whose household countable income equal is between than 25% and 138% FPL are eligible for Medicaid Expansion.

**Pregnant Women**
Medicaid provides temporary medical coverage to eligible pregnant women with countable household income equal to or less than 157% FPL who meet the nonfinancial criteria for Affordable Care Act (ACA) Pregnancy Medicaid. The coverage extends for 60 days beyond the child's birth.

## Medicaid Eligibility – Special Populations

**Breast and Cervical Cancer Treatment**
Individuals who are screened by a Montana Breast and Cervical Health Program (MBCHP) and are subsequently diagnosed with breast and/or cervical cancer or pre-cancer may be eligible for Medicaid.

Qualifying recipients must:

- Have received a breast and/or cervical health screening through the Montana Breast and Cervical Health Program
- Have been diagnosed with breast and/or cervical cancer or pre-cancer as a result of the screening
- Not have health insurance or other coverage for breast and/or cervical cancer, including Medicare
- Not be eligible for any other **Categorically Needy** Medicaid program; and
- Recipients' countable income must be at or below 250% FPL.

**Severe and Disabling Mental Illness**
Individuals who are assessed by a licensed mental health professional and are subsequently diagnosed with a Severe and Disabling Mental Illness through diagnosis, functional impairment, and duration of illness, may be eligible for the Waiver for Additional Services and Populations:

Qualifying individuals must:

- Have a Severe and Disabling Mental Illness
- Otherwise ineligible for Medicaid
- Individual must be at least 18 years of age; and
- Have a family income 0-138% of FPL and are eligible for or enrolled in Medicare; or 139-150% of FPL regardless of Medicare status.

# Medicaid Eligibility – People with Disabilities

**Blind/Disabled**

Individuals may be eligible for Medicaid if determined blind or disabled using Social Security criteria, and if their income is within allowable limits and their resources do not exceed $2000 for an individual or $3000 for a couple. Income limits for the Aged, Blind, Disabled programs are $771 per month for an individual and $1157 for a couple.

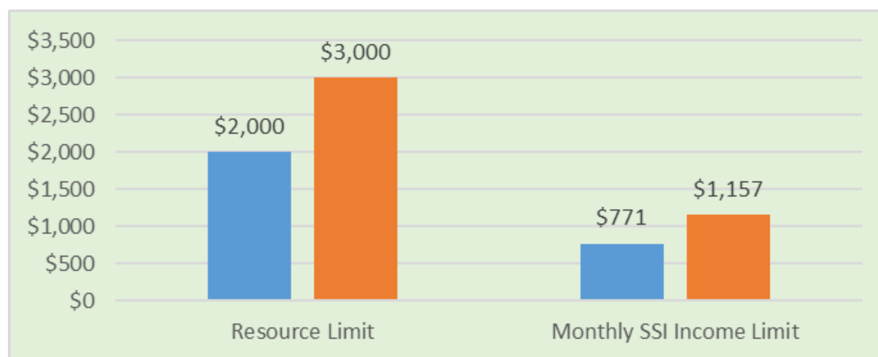
**Aged, Blind, or Disabled Recipients of Supplemental Security Income (SSI)**

In Montana, any aged, blind, or disabled individual determined eligible for SSI receives Medicaid. This support enables them to receive regular medical attention and maintain their independence.

**Montana Medicaid for Workers with Disabilities (MWD)**

Allows certain individuals who meet Social Security's disability criteria to receive Medicaid benefits through a cost share. This is based on a sliding scale according to an individual's income. Individuals must be employed (either through an employer or self-employed) to be considered for this program. MWD resource and income standards are significantly higher than many other Medicaid programs: $15,000 for an individual and $30,000 for a couple; while the countable income limit is 250% of the Federal Poverty Level (FPL).

FIGURE 1 – 2019 SSI MONTHLY INCOME STANDARDS




For more information, please refer to: Medical Assistance (MA) Policy Manual

# Medicaid Eligibility – Categorically and Medically Needy

**Categorically Needy** – Assists individuals with an attribute (disability, pregnant, child, etc.) for which there is a mandatory or optional Medicaid program.

**Medically Needy** – Assists individuals whose income is too high for Medicaid but would otherwise qualify

- Provides coverage for the aged, blind, disabled, pregnant women, and children, whose income exceeds the income standards, but have significant medical expenses
- Individuals may qualify for benefits through a process known as Spend Down:
  - Incurring medical expenses equal to spend down amount;
  - Making a cash payment to the department; or
  - Paying both incurred medical expenses and cash payment

**Table 3 –Limits for Medically Needy SFY 2019**

| Family Size | Resource Limit | Monthly Income Limit |
|---|---|---|
| 1 | $2,000/$3,000* | $525 |
| 2 | $3,000 | $525 |
| 3 | $3,000 | $658 |
| 4 | $3,000 | $792 |
| 5 | $3,000 | $925 |
| 6 | $3,000 | $1,058 |
| *$2,000 for aged, blind, or disabled individuals, $3,000 for children, pregnant women and for aged, blind, or disabled couples. | | |

## Medicaid Benefits

The Montana Medicaid benefits packages meet federal guidelines. Medicaid benefits are divided into two classes: *mandatory* and *optional*. Federal law requires that adults eligible for Medicaid are entitled to mandatory services, unless waived under Section 1115 of the Social Security Act.

States may elect to cover optional benefits. Montana has chosen to cover several cost-effective optional benefits. The table below provides some examples of mandatory and optional benefits:

| **Mandatory Benefits** | **Optional Benefits** |
|---|---|
| Physician and Nurse Practitioner | Outpatient Drugs |
| Nurse Midwife | Dental and Denturist Services |
| Medical and Surgical Service of a Dentist | Ambulance |
| Laboratory and X-ray | Physical and Occupational Therapies and Speech Language Pathology |
| Inpatient Hospital (excluding inpatient services in institutions for mental disease) | Home and Community Based Services |
| Outpatient Hospital | Eyeglasses and Optometry |
| Federally Qualified Health Centers (FQHCs) | Personal Assistance Services |
| Rural Health Clinics (RHCs) | Targeted Case Management |
| Family Planning | Podiatry |
| Early and Periodic Screening, Diagnosis and Treatment (EPSDT) | Community First Choice |
| Nursing Home Facility | |
| Home Health | |
| Durable Medical Equipment | |
| Transportation | |
| Behavioral Health | |

Under federal *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)* regulations, a state must cover all medically necessary services to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen for individuals under age 21. This is true of whether the service or item is otherwise included in the State Medicaid plan.

## Population Specific Supports

The Montana Medicaid program includes additional benefits not available to all members. These supports are available to populations with specific health conditions and/or functional impairments. These benefits are authorized under a combination of the state plan amendments and waiver authorities.

| Populations | Population Supports | Forms of Authorization |
|---|---|---|
| **Aged and Physically Disabled** | | |
| | Basic Medicaid | State Plan<br>1115 Waiver |
| | Home and Community Based Services | 1915(c) Waiver,<br>1915(b) Waiver |
| | Home and Community Based Services - Self Directed | 1915(c) Waiver |
| | Community First Choice Services | State Plan |
| **Developmentally Disabled** | | |
| | Basic Medicaid | State Plan<br>1115 Waiver |
| | Home and Community Based Services | 1915(c) Waiver,<br>1915(b) Waiver |
| | Home and Community Based Services - Self Directed | 1915(c) Waiver |
| | Community First Choice Services | State Plan |
| **Severe and Disabling Mental Illness** | | |
| | Basic Medicaid | State Plan<br>1115 Waiver |
| | Home and Community Based Services | 1915(c) Waiver,<br>1915(b) Waiver |
| | Home and Community Based Services - Self Directed | 1915(c) Waiver |
| | Community First Choice Services | State Plan |
| | Program for Assertive Community Treatment | State Plan |

# Waivers – The Basics

- **Section 1915(c) waivers** – Also known as Medicaid Home and Community-Based Services (HCBS) waivers, these waivers enable states to pay for alternative medical care and support services, to help people continue living in their homes and/or communities, rather than in an institution (nursing facility, hospital, or Intermediate Care Facility for Individuals with Developmental Disability). States have the option to determine eligibility by the income of the affected individual, instead of the income of the entire family.

- **Section 1115 waivers** - Authorizes experimental, pilot, or demonstration projects.

- **Section 1915(b) waivers** – Allows states to waive statewideness, comparability of services, and freedom of choice. There are four 1915(b) waivers available:
  - (b)(1) to mandate Medicaid enrollment into managed care
  - (b)(2) to utilize a “central broker”
  - (b)(3) to use cost savings to provide additional services
  - (b)(4) to limit the number of providers for services

- **Section 1135 waivers** - In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements. During an emergency, sections 1135 or 1812(f) of the SSA allow CMS to issue blanket waivers to help beneficiaries access care. When a blanket waiver is issued, providers don't have to apply for an individual 1135 waiver.

States often combine waivers and state plan authorities to achieve their goals. A 1915(b)/1915(c) or 1115/1915(b) are the most common combinations. Waivers are expected to be cost neutral to the federal government.

# 1915c Waiver – HCBS for Individuals with Developmental Disabilities

A copy of the current waiver is available at:

**1915(c) HCBS 0208 DD Comprehensive Services Waiver for Individuals with Developmental Disabilities - Developmental Services Division**

**Purpose**

Home and Community Based Service (HCBS) waivers authorized under Section 1915(c) of the Social Security Act allow for the payment of home and community-based services to people who would otherwise require institutional care. The **0208 Comprehensive Services Waiver** (HCBS DD Waiver) allows individuals with developmental disabilities to live in their community while decreasing the cost of their health care.

**Waiver Participants**

In SFY 2020, an average of 2,540 Montanan's, each month, received services funded by the Comprehensive Services (HCBS) Waiver. The waiver supported successful community living for 2,570 Montanans during SFY 2020. The waiver funds services to Medicaid members of all ages with service plans specific to their individual needs. The waiver includes an option for self-directing the individual care plan.

**Services**

The waiver offers 32 separate services, provided in a variety of residential and work settings. Waiver participants live in a variety of circumstances, including family homes, group homes, apartments, foster homes and assisted living situations. Work service options covered by this waiver include day supports and activities, and supported employment (including individual and group supports). A variety of other services and supports are available, including extended State Plan services.

**Cost Plans**

The SFY 2020 average cost plan per person is $56,187 per year. The cost plans ranged from $1,266 to $477,381. These costs do not include the cost of Medicaid State Plan services, which are available to all eligible members such as inpatient hospital, physician, pharmacy, durable medical equipment, physical therapy, behavioral health services and speech therapy.

Copies of the current waivers are available at:

**1915(b) (4) and 1915(c) Montana Big Sky Waiver – Senior and Long-Term Care Division**

## 1915c Waiver – HCBS for Individuals for Aged and Physically Disabled

**Purpose**

Home and Community Based Service (HCBS) waivers authorized under Section 1915(c) of the Social Security Act allow for the payment of home and community-based services to people who would otherwise require more costly institutional care. The **Big Sky Waiver** (HCBS Waiver), in combination a 1915(b)(4) waiver, to allows nursing home level members to live in their community while decreasing the cost of their health care.

**Waiver Participants**

Every year approximately 2,500 Montanan's receive Montana Big Sky Waiver services, supporting independent living for the elderly (age 65 and older) and people with physical disabilities. In SFY 2020, an average of 2,198 Montanan's, each month, received services funded by the Big Sky Waiver. Members must be financially eligible for Medicaid and meet the program's nursing facility or hospital level of care requirements. The waiver includes an option for self-directing services under the Big Sky Bonanza program.

**Services**

The waiver offers a number of different services including case management, respite, adult residential care (assisted living facilities), private duty nursing for adults, home and vehicle modifications, and specialized medical equipment and supplies not covered by other third parties. Services under the Big Sky Waiver are often partnered with state plan in home support services.

**Waiver slots**

The Big Sky Waiver slots costs do not include the cost of Medicaid State Plan services, which are available to eligible Medicaid members. Examples of services that are available under the Medicaid State Plan include physician, pharmacy, durable medical equipment, occupational therapy, physical therapy, behavioral health services and speech therapy.

# 1915c Waiver – HCBS for Individuals with SDMI

Copies of the current waivers are available at:

[1915(c) Home and Community Based Services (HCBS) SDMI Waiver - Addictive and Mental Disorders Division]

**Purpose**

Home and Community Based Service (HCBS) waivers authorized under Section 1915(c) of the Social Security Act allow for the payment of home and community-based services to people who would otherwise require more costly institutional care. The HCBS **SDMI Waiver** provides Medicaid reimbursement for community-based services for adults with SDMI who meet criteria for nursing home level of care. This waiver is partnered with a 1915(b)(4) waiver to deliver services statewide via a limited number of case management providers.

**Members**

The waiver's 357 slots are distributed among two contractors that provide case management services statewide. Partners in Home Care provides case management services in Mineral, Missoula and Ravalli Counties; Benefis Spectrum Medical provides case management services for the remainder of the state.

**Services**

A registered nurse and a social worker coordinate services through case management to provide services including: adult day health, case management, community transition, consultative clinical and therapeutic services, environmental accessibility adaptations, habilitation aide, health and wellness, homemaker, homemaker chore, life coach, meals, non-medical transportation, pain and symptom management, peer support, personal assistance attendant, personal emergency response system, prevocational services, private duty nursing, residential habilitation, respite, specialized medical equipment and supplies, specially trained attendants, and supported employment.

# 1115 Waiver – Waiver for Additional Services and Populations

The Waiver for Additional Services and Populations (WASP) covers adults with serious and disabling mental illness between 139-150% FPL who do not otherwise qualify for Medicaid and dental treatment services above the Medicaid State Plan cap of $1,125 per individual for people determined categorically eligible as Aged, Blind or Disabled.

The waiver is available at: **1115 Waiver for Additional Services and Populations (WASP) – Health Resources and Addictive and Mental Disorders Divisions**

# 1115 Waiver – Plan First

The Plan first waiver is an 1115 waiver with a limited benefit plan. The program covers family planning services such as office visits, contraceptive supplies, laboratory services, and testing and treatment of Sexually Transmitted Diseases (STDs). Eligibility is open to women ages 19 through 44 (who are able to bear children and not presently pregnant) with an annual household income up to 211% FPL. Program is limited to 4,000 women at any given time.

The waiver is available at: **1115 Plan First Waiver – Health Resources Division**

# 1115 Waiver – Health and Economic Livelihood Program

The Health and Economic Livelihood Program (HELP) is the 1115 Waiver implementing Medicaid expansion in Montana. The waiver provides standard Medicaid coverage to low income families between 25% and 138% FPL as well as low income individuals up to 138% FPL. The HELP waiver moved some Medicaid members to the expansion eligibility group, decreasing the required state match as well as providing coverage to previously ineligible Montanans.

The current approved waiver is available at: **1115 HELP Waiver**

## 1915(b) Waiver – Passport to Health

The Passport to Health is a 1915(b) waiver that allows for care coordination services from a limited number of providers. The program minimizes ineffective or inappropriate medical care to Medicaid and HMK Plus members. The waiver, which involves about 70 percent of all Montana Medicaid members, has four program components:

- **Passport to Health**
  - Primary Care Case Management (PCCM) program
  - Members choose or are assigned a primary care provider, who delivers all medical services or furnishes referrals for other medically-necessary care
  - Most Medicaid and HMK Plus eligible individuals are enrolled in this program

- **Team Care**
  - Reduces inappropriate or excessive utilization of health care services, including overutilization of hospital emergency rooms
  - Identifies candidates through referrals from providers, Health Improvement Program care managers, Drug Utilization Review Board, or through claim review
  - Individuals are enrolled for at least 12 months and are required to receive services from one pharmacy and one medical provider
  - Approximately 360 Medicaid and HMK Plus members are enrolled as of December 2020.

- **Tribal Health Improvement Program (T-HIP)**

  The Tribal Health Improvement Program (T-HIP) is a historic partnership between the Tribal, State and Federal governments to address factors that contribute to health disparities in the American Indian population. This program has a three-tiered structure, creating a unique opportunity for each Tribe to build and operate health promotion programs and associated activities that are culturally based and relevant to their members and community:

  - Services provided under Tier 1 seek to improve the health of members who have chronic illnesses or are at risk of developing serious health conditions through intensive care coordination of individual members. The services in Tier 1 also seek to enhance the communication and coordination link between the member and the Passport primary care provider.

- Tier 2 and Tier 3 address specific health focus areas that contribute to health disparities. Activities generally focus on improving the health of a population rather than individual members. (i.e. obesity prevention program for grade school youth.)

## Nurse First Advice Line

- 24/7 Nurse Advice Line, available to all Medicaid and HMK Plus members
- Clinically-based algorithms (vendor provided) direct callers to the most appropriate level of care: self-care, provider visit, or emergency department visit
- Continuously monitors quality, access to care, and health outcomes among members and providers, reducing Medicaid costs

## Indian Health Service (IHS) and Tribal Health Activities

Health care delivery is a collaborative effort:

- Indian Health Service (IHS) – (100% federally funded)
- Tribal Health 638 Programs/Departments - (100% federally funded)
- Urban Indian Health Centers – (65% federally funded / 35% state funded)

Combined in-patient and out-patient services offered at:

- Blackfeet Community Hospital
- Crow/Northern Cheyenne Hospital
- Fort Belknap Hospital
- Confederated Salish-Kootenai Tribes

Out-patient services are also offered at Indian Health Service Units and Tribal Health Programs/Departments:

- Northern Cheyenne Service IHS Unit
- Fort Peck IHS Service Unit
- Blackfeet Tribal Health Department
- Chippewa Cree Tribal Health Department (Rocky Boy Health Center)
- Confederated Salish and Kootenai Tribal Health Department
- Crow Tribal Health Department
- Fort Belknap Tribal Health Department
- Fort Peck Tribal Health Department
- Northern Cheyenne Tribal Health (Northern Cheyenne Board of Health)

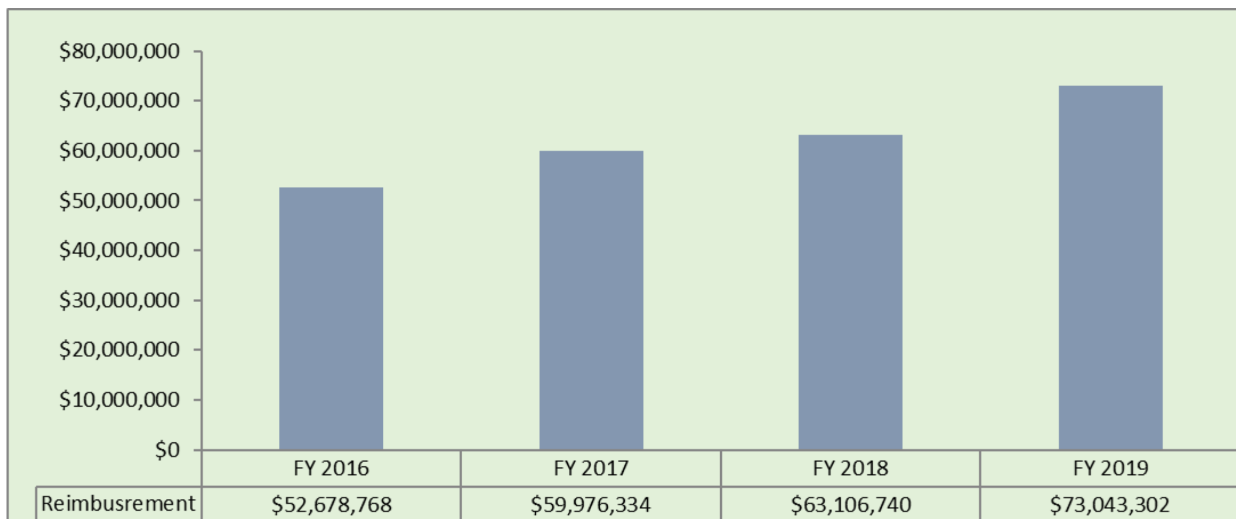
Five major Urban Indian Health Centers provide care to American Indians who reside off a respective Indian reservation:

- Billings Urban Indian Health and Wellness Center
- Helena Indian Alliance
- Indian Family Health Clinic of Great Falls
- Missoula All Nations Health Center
- North American Indian Alliance of Butte

**TABLE 4 – AMERICAN INDIAN MEDICAID PAYMENTS**

| Organization | Location | Eligible Client | Services Provided | Federal Match |
|---|---|---|---|---|
| Indian Health Service | Reservation | Tribal Member or Descendent | In-patient – Blackfeet, Crow/Northern Cheyenne and Fort Belknap Outpatient – All Reservations – services offered vary | 100% Federal Funds |
| Tribal Health (operating under a 638 compact) or contract | Reservation | Tribal Member or Descendent | Outpatient – services offered vary. Nursing Facility - Blackfeet, Crow | 100% Federal Fund |
| Urban Indian Health Centers | Billings Butte Great Falls Helena Missoula | Tribal Member or Descendent Plus Non-Natives | Outpatient – services offered vary | 65% Federal Funds/ 35% State Funds |

Figure 2 – Indian Health Service/Tribal Reimbursement by State Fiscal Year



## Medicaid Revenue Reports

Every year, DPHHS prepares Medicaid Revenue Reports and discusses them with the Tribal Governing bodies (Tribal Council), the Indian Health Service Units, and the Area Office. Specific information includes Medicaid revenue received, billable services by type, and where payment was sent. The Medicaid Revenue Reports serve as a useful tool for Tribes and IHS, as they compare information and identify opportunities for future billing.

## Medicaid Tribal Consultations

DPHHS formally consults with Tribal Governments, Indian Health Service, and the Urban Indian programs on a regular basis, to discuss the Medicaid program and its impact on American Indians and Tribal and urban communities.

## Medicaid Administrative Match (MAM)

MAM is a federal reimbursement program for the costs of “administrative activities” that directly support efforts to identify, and/or to enroll individuals in the Medicaid program, or to assist those already enrolled in Medicaid to access benefits. Through MAM, Tribes who have entered into contracts with the State of Montana are reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal Cost Allocation Plan gives Tribes a mechanism to seek reimbursement for the Medicaid administrative activities they perform. The program, the first of its kind in the country, began July 1, 2008. The Chippewa Cree Tribe and the Northern Cheyenne Tribe are currently under contract.

## Medicaid Eligibility Determination Agreements

The partnerships that exist between DPHHS and the Tribes in Montana are important for delivering quality services in a cost-efficient manner. Since federal law allows, DPHHS has entered into agreements with four Tribes - Chippewa Cree Tribes, Confederated Salish and Kootenai Tribes, Blackfeet Tribe and the Fort Belknap Tribes allowing the Tribes to determine Medicaid eligibility on their respective Indian reservations. This is a collaborative effort and partnership that allows Tribal members to apply for services locally and helps to remove barriers and delays that might otherwise impede tribal members from obtaining Medicaid benefits and proper medical care.

**Nursing Facility Reimbursement**

DPHHS and the Crow and Blackfeet Tribes negotiated a new payment rate that substantially increased reimbursement for Tribally-owned nursing facilities. This re-financing initiative made the nursing homes eligible for 100% federal match for the majority of their patients. This CMS-approved state plan has resulted in significant savings to the state general fund.

# Standard Medicaid Enrollment and Expenditures

### TABLE 5 – SUMMARY OF STANDARD MEDICAID ENROLLED PERSONS FOR SFY 2019

| Beneficiary Characteristic | Average Monthly Enrollment: All | Aged | Blind & Disabled | Adults | Children | % of Medicaid Total | % of Montana Population |
|---|---|---|---|---|---|---|---|
| **Total** | **142,623** | **7,812** | **18,347** | **19,351** | **97,113** | **100%** | |
| **Age** | | | | | | | |
| 0 to 1 | 6,273 | 0 | 38 | 0 | 6,236 | 4% | 1% |
| 1 to 5 | 29,996 | 0 | 363 | 0 | 29,633 | 21% | 6% |
| 6 to 18 | 63,444 | 0 | 2,200 | 0 | 61,244 | 44% | 16% |
| 19 to 20 | 1,776 | 0 | 406 | 1,370 | 0 | 1% | 3% |
| 21 to 64 | 32,877 | 0 | 14,895 | 17,981 | 0 | 23% | 56% |
| 65 and older | 8,257 | 7,812 | 445 | 0 | 0 | 6% | 19% |
| | 142,623 | 7,812 | 18,347 | 19,351 | 97,113 | | |
| **Gender** | | | | | | | |
| Male | 66,842 | 2,750 | 9,289 | 5,592 | 49,211 | 47% | 50% |
| Female | 75,782 | 5,062 | 9,058 | 13,759 | 47,902 | 53% | 50% |
| | 142,623 | 7,812 | 18,347 | 19,351 | 97,113 | | |
| **Race** | | | | | | | |
| White | 92,676 | 5,917 | 14,086 | 13,093 | 59,580 | 65% | 91% |
| American Indian | 30,287 | 877 | 3,036 | 4,242 | 22,131 | 21% | 7% |
| Other * | 19,660 | 1,017 | 1,225 | 2,016 | 15,402 | 14% | 2% |
| | 142,623 | 7,812 | 18,347 | 19,351 | 97,113 | | |
| **Assistance Status** | | | | | | | |
| Medically Needy | 617 | 381 | 236 | 0 | 0 | 0% | |
| Categorically Needy | 142,006 | 7,431 | 18,111 | 19,351 | 97,113 | 100% | |
| | 142,623 | 7,812 | 18,347 | 19,351 | 97,113 | | |
| **Medicare Status** | | | | | | | |
| Part A and B | 16,124 | 7,131 | 7,790 | 1,201 | 2 | 11% | |
| Part A only | 93 | 46 | 32 | 15 | 0 | 0% | |
| Part B only | 540 | 525 | 15 | 0 | 0 | 0% | |
| None | 125,866 | 110 | 10,510 | 18,135 | 97,111 | 88% | |
| | 142,623 | 7,812 | 18,347 | 19,351 | 97,113 | | |
| **Medicare Saving Plan (not included in total)** | | | | | | | |
| QMB Only | 5,803 | 2,957 | 2,846 | 0 | 0 | | |
| SLMB - QI Only | 5,404 | 3,357 | 2,047 | 0 | 0 | | |
| **Other Medicaid Eligibles (not included in total)** | | | | | | | |
| HK Exp (CHIP Funded) | 5,253 | 0 | 0 | 0 | 5,253 | | |
| Plan First Waiver | 1,528 | 0 | 0 | 1,528 | 0 | | |

**FIGURE 3 – MEDICAID 2019 ENROLLMENT AND EXPENDITURES BY MAJOR AID CATEGORIES**

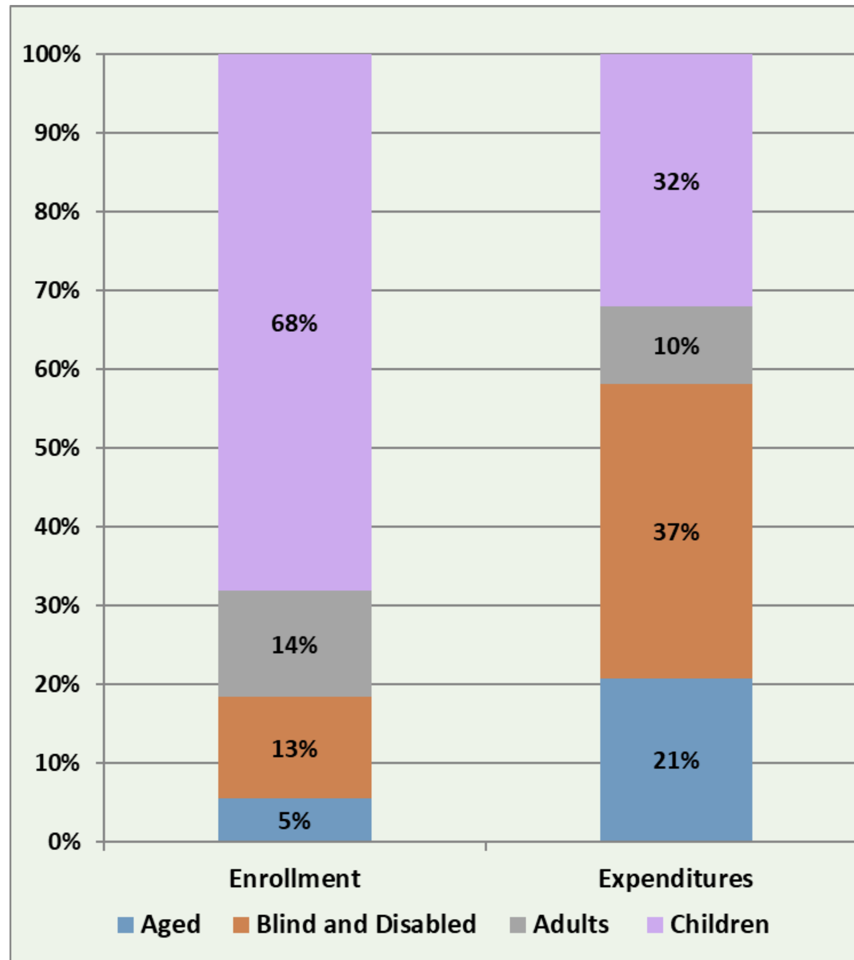



**TABLE 6 –ENROLLMENT AND EXPENDITURES BY STANDARD MEDICAID CATEGORY SFY 2019**

| Aid Category | Average Monthly Enrollment | Percent of Enrollment | Expenditures | Percent of Expenditures |
|---|---|---|---|---|
| Aged | 7,812 | 5% | $231,675,743 | 21% |
| Blind and Disabled | 18,347 | 13% | $419,214,105 | 37% |
| Adults | 19,351 | 14% | $109,830,052 | 10% |
| Children | 97,113 | 68% | $358,163,477 | 32% |
| Total | 142,623 | 100% | $1,118,883,376 | 100% |

*Note that the above graphs do not include HMK (CHIP Funded), Expansion, Medicare Savings Plan, or Plan First Waiver clients.*

**FIGURE 4 – STANDARD MEDICAID ENROLLMENT – ADULTS AND CHILDREN (Excludes Medicare Savings Plan Only)**

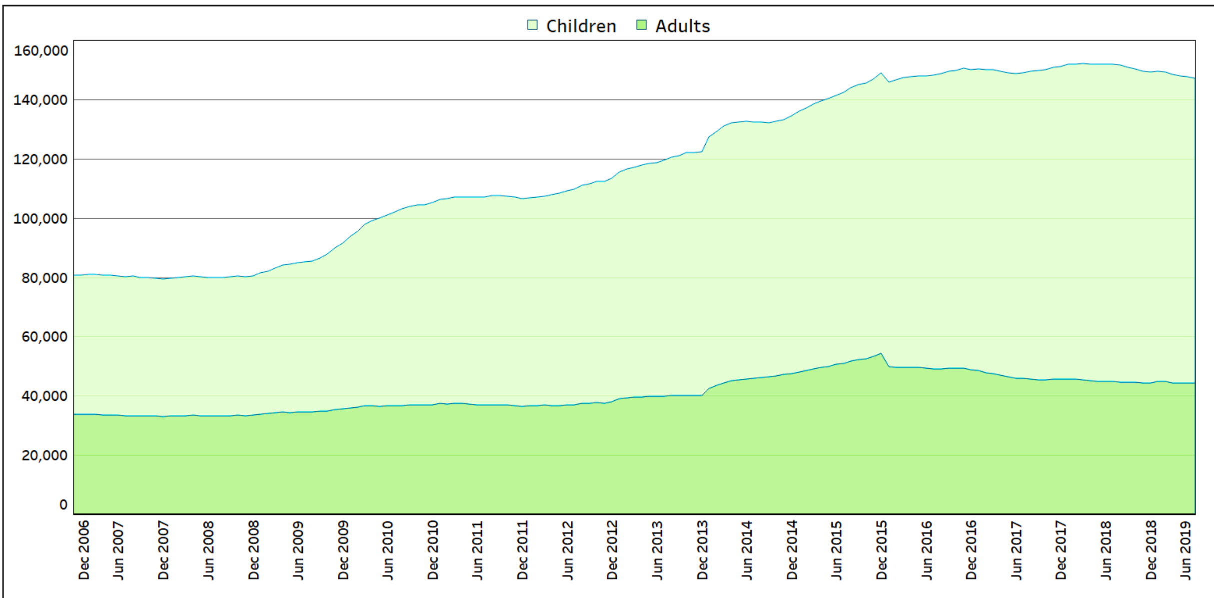



**FIGURE 5 – DISABLED MEDICAID ENROLLMENT – ADULTS AND CHILDREN (Excludes Medicare Savings Plan Only)**

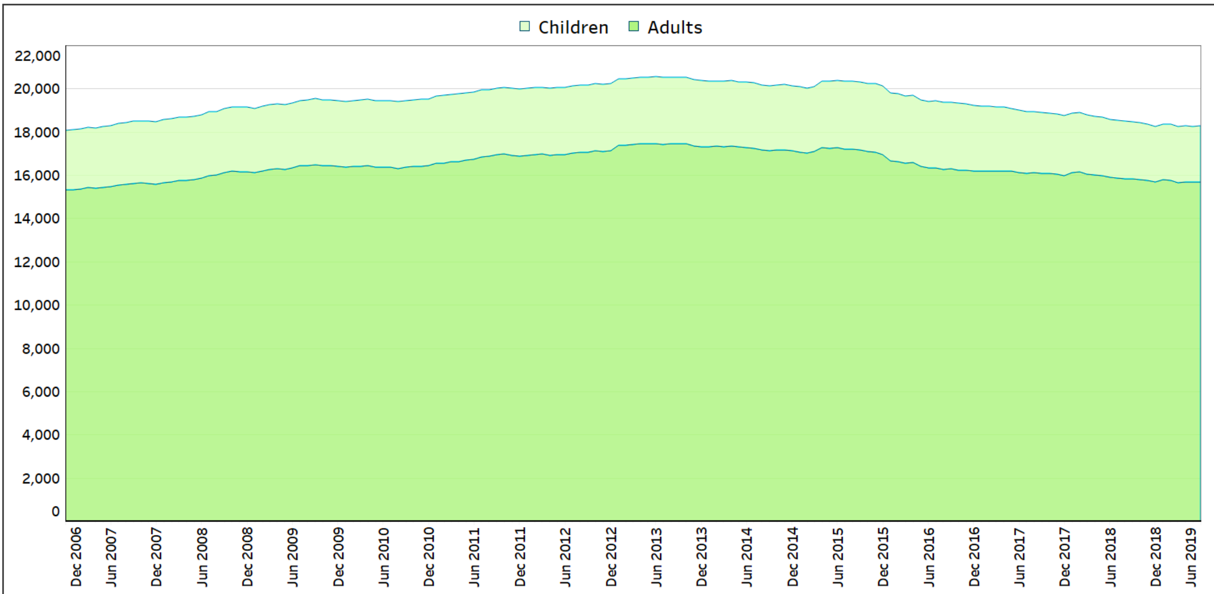


**FIGURE 6 – MEDICAID ENROLLMENT – AGE 65 AND OLDER (Excludes Medicare Savings Plan Only)**

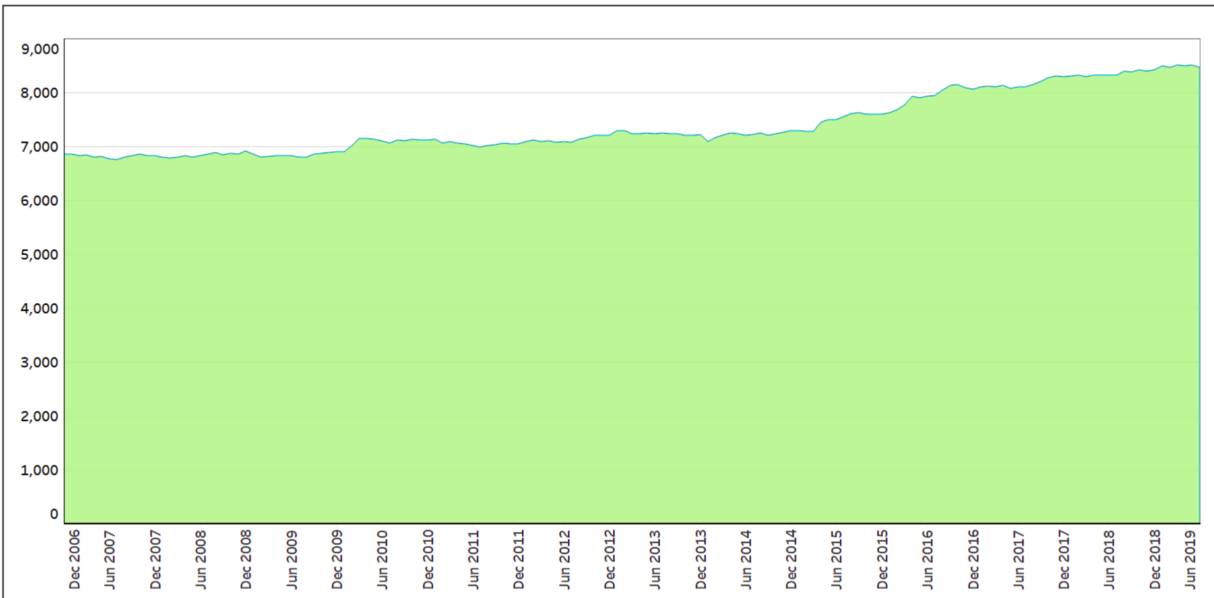



**FIGURE 7 – FAMILY MEDICAID ENROLLMENT (EXCLUDES MEDICARE SAVINGS PLAN ONLY)**

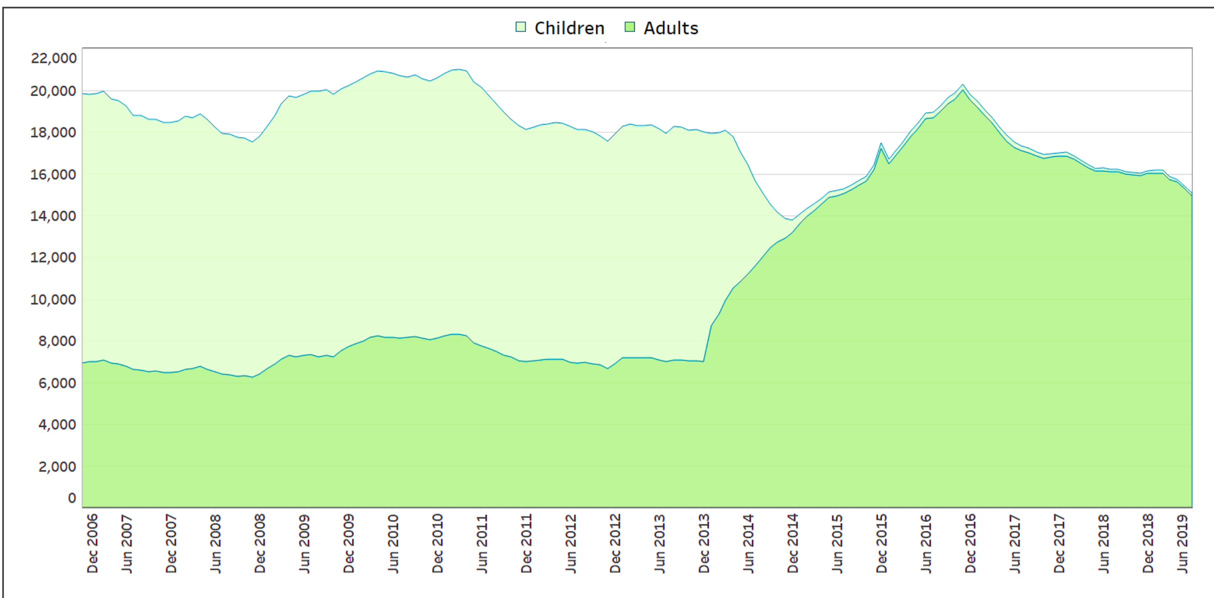


**Figure 8 – Medicaid Poverty Child Enrollment (Excludes Medicare Savings Plan Only)**

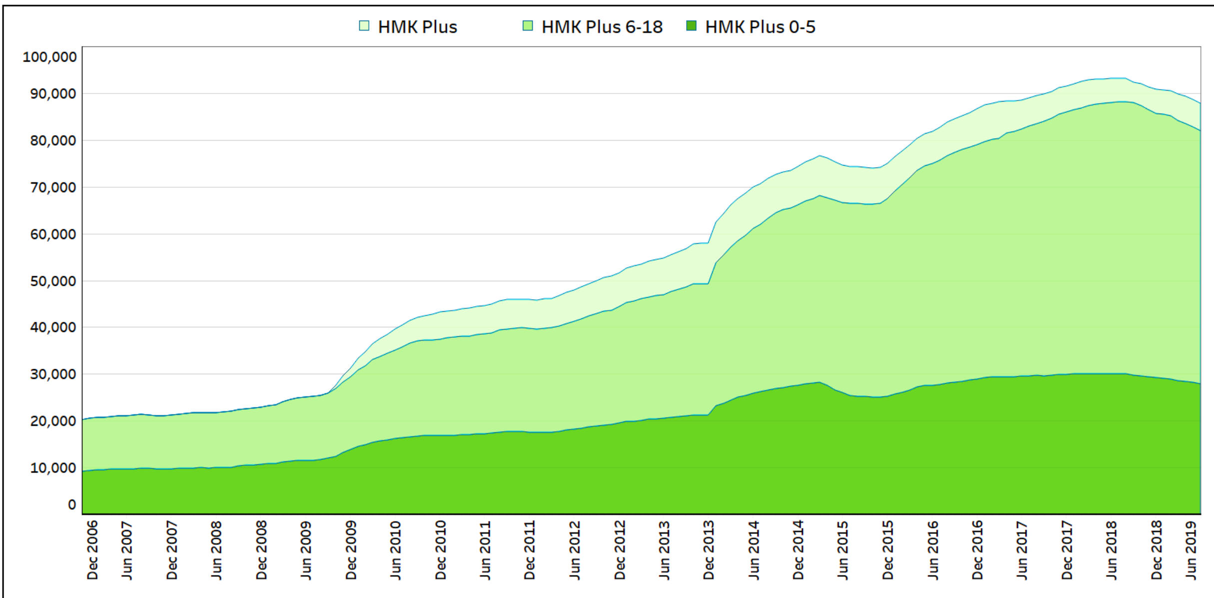
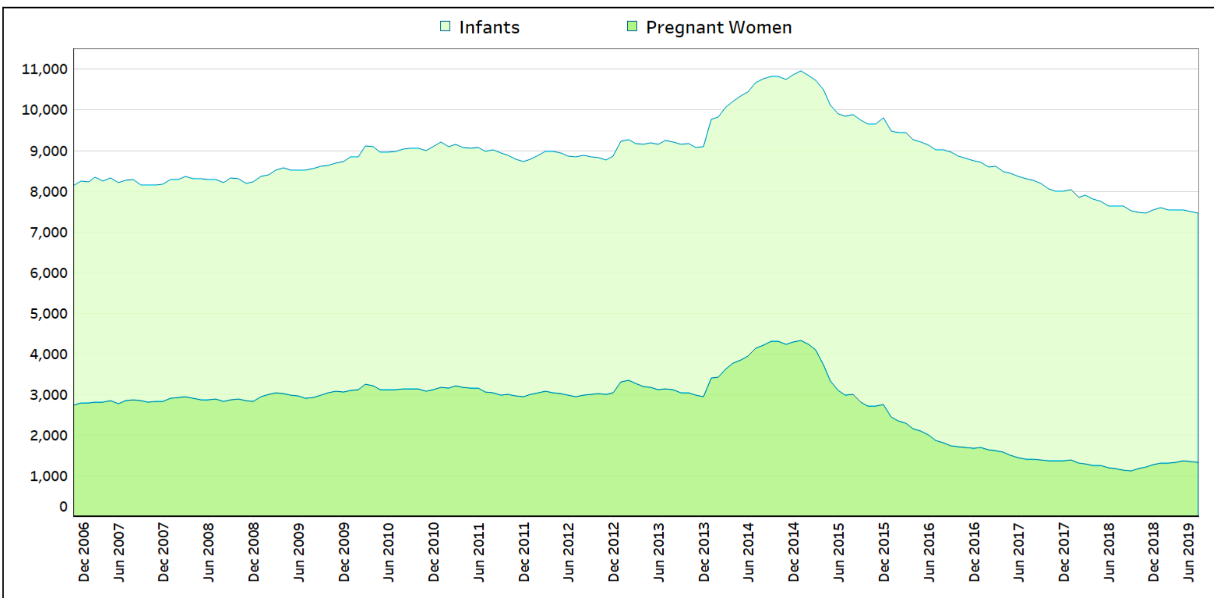



**Figure 9 – Medicaid Enrollment – Pregnant Women and Infants**



### Table 7 – Standard Medicaid Enrollment and Expenditures by County SFY 2019

| County | County Population 7/1/2019 | Average Monthly Medicaid Enrollment | Percent on Medicaid | Rank by Percent on Medicaid | Total County Expenditures | Average Expenditure per Enrollee | Rank by Average Expenditure per Enrollee |
|---|---|---|---|---|---|---|---|
| BEAVERHEAD | 9,453 | 1,056 | 11% | 34 | $9,157,819 | $8,671 | 18 |
| BIG HORN | 13,319 | 4,425 | 33% | 2 | $29,519,661 | $6,672 | 43 |
| BLAINE | 6,681 | 1,698 | 25% | 4 | $13,590,587 | $8,003 | 23 |
| BROADWATER | 6,237 | 532 | 9% | 50 | $4,038,440 | $7,596 | 27 |
| CARBON | 10,725 | 1,032 | 10% | 41 | $6,974,779 | $6,761 | 42 |
| CARTER | 1,252 | 106 | 8% | 51 | $573,990 | $5,428 | 50 |
| CASCADE | 81,366 | 11,753 | 14% | 20 | $100,621,864 | $8,561 | 19 |
| CHOUTEAU | 5,635 | 543 | 10% | 40 | $3,259,758 | $6,004 | 46 |
| CUSTER | 11,402 | 1,619 | 14% | 22 | $16,314,791 | $10,078 | 7 |
| DANIELS | 1,690 | 116 | 7% | 55 | $1,230,885 | $10,657 | 6 |
| DAWSON | 8,613 | 911 | 11% | 36 | $9,944,324 | $10,915 | 3 |
| DEER LODGE | 9,140 | 1,278 | 14% | 23 | $13,825,934 | $10,816 | 4 |
| FALLON | 2,846 | 297 | 10% | 39 | $2,010,968 | $6,779 | 41 |
| FERGUS | 11,050 | 1,351 | 12% | 30 | $15,353,958 | $11,363 | 2 |
| FLATHEAD | 103,806 | 12,970 | 12% | 29 | $89,537,857 | $6,904 | 40 |
| GALLATIN | 114,434 | 7,609 | 7% | 56 | $41,547,102 | $5,461 | 49 |
| GARFIELD | 1,258 | 166 | 13% | 26 | $1,207,692 | $7,286 | 33 |
| GLACIER | 13,753 | 4,602 | 33% | 1 | $40,059,268 | $8,706 | 17 |
| GOLDEN VALLEY | 821 | 146 | 18% | 11 | $721,047 | $4,947 | 53 |
| GRANITE | 3,379 | 290 | 9% | 48 | $2,013,973 | $6,939 | 38 |
| HILL | 16,484 | 3,842 | 23% | 6 | $28,256,141 | $7,355 | 32 |
| JEFFERSON | 12,221 | 1,088 | 9% | 47 | $10,059,752 | $9,243 | 13 |
| JUDITH BASIN | 2,007 | 186 | 9% | 45 | $939,750 | $5,064 | 52 |
| LAKE | 30,458 | 6,149 | 20% | 8 | $48,437,980 | $7,877 | 25 |
| LEWIS AND CLARK | 69,432 | 8,150 | 12% | 32 | $58,803,363 | $7,215 | 35 |
| LIBERTY | 2,337 | 285 | 12% | 31 | $2,035,199 | $7,154 | 36 |
| LINCOLN | 19,980 | 3,467 | 17% | 12 | $27,782,902 | $8,013 | 22 |
| MADISON | 8,600 | 606 | 7% | 54 | $5,571,846 | $9,189 | 14 |
| MCCONE | 1,664 | 157 | 9% | 43 | $685,307 | $4,360 | 56 |
| MEAGHER | 1,862 | 339 | 18% | 10 | $2,347,416 | $6,921 | 39 |
| MINERAL | 4,397 | 712 | 16% | 15 | $3,792,021 | $5,323 | 51 |
| MISSOULA | 119,600 | 13,334 | 11% | 35 | $120,293,591 | $9,022 | 16 |
| MUSSELSHELL | 4,633 | 737 | 16% | 16 | $6,991,126 | $9,488 | 12 |
| PARK | 16,606 | 1,737 | 10% | 38 | $16,674,089 | $9,600 | 11 |

### TABLE 8 – STANDARD MEDICAID ENROLLMENT AND EXPENDITURES BY COUNTY SFY 2019 (CONTINUED)

| County | County Population 7/1/2019 | Average Monthly Medicaid Enrollment | Percent on Medicaid | Rank by Percent on Medicaid | Total County Expenditures | Average Expenditure per Enrollee | Rank by Average Expenditure per Enrollee |
|---|---|---|---|---|---|---|---|
| PETROLEUM | 487 | 42 | 9% | 49 | $184,925 | $4,438 | 55 |
| PHILLIPS | 3,954 | 678 | 17% | 13 | $5,756,465 | $8,496 | 20 |
| PONDERA | 5,911 | 1,310 | 22% | 7 | $10,419,028 | $7,951 | 24 |
| POWDER RIVER | 1,682 | 151 | 9% | 46 | $1,078,354 | $7,149 | 37 |
| POWELL | 6,890 | 797 | 12% | 33 | $8,580,784 | $10,762 | 5 |
| PRAIRIE | 1,077 | 139 | 13% | 28 | $1,347,952 | $9,669 | 10 |
| RAVALLI | 43,806 | 5,687 | 13% | 27 | $43,134,128 | $7,585 | 28 |
| RICHLAND | 10,803 | 1,139 | 11% | 37 | $7,484,255 | $6,570 | 44 |
| ROOSEVELT | 11,004 | 3,583 | 33% | 3 | $35,906,628 | $10,021 | 8 |
| ROSEBUD | 8,937 | 2,258 | 25% | 5 | $16,950,450 | $7,507 | 29 |
| SANDERS | 12,113 | 1,967 | 16% | 14 | $14,684,356 | $7,466 | 30 |
| SHERIDAN | 3,309 | 309 | 9% | 44 | $2,279,571 | $7,373 | 31 |
| SILVER BOW | 34,915 | 5,246 | 15% | 18 | $48,078,320 | $9,165 | 15 |
| STILLWATER | 9,642 | 923 | 10% | 42 | $5,529,950 | $5,989 | 47 |
| SWEET GRASS | 3,737 | 299 | 8% | 53 | $2,505,932 | $8,374 | 21 |
| TETON | 6,147 | 910 | 15% | 19 | $5,520,938 | $6,067 | 45 |
| TOOLE | 4,736 | 654 | 14% | 24 | $5,031,683 | $7,699 | 26 |
| TREASURE | 696 | 105 | 15% | 17 | $486,626 | $4,646 | 54 |
| VALLEY | 7,396 | 1,055 | 14% | 21 | $10,382,749 | $9,841 | 9 |
| WHEATLAND | 2,126 | 423 | 20% | 9 | $2,413,125 | $5,699 | 48 |
| WIBAUX | 969 | 81 | 8% | 52 | $1,261,566 | $15,543 | 1 |
| YELLOWSTONE | 161,300 | 21,498 | 13% | 25 | $155,307,655 | $7,224 | 34 |
| Other / Institution | | 81 | | | $382,755 | | |
| **Sub Total** | **1,068,778** | **142,623** | **13%** | | **$1,118,883,376** | **$7,845** | |
| Plan First | | 1,528 | | | $245,035 | $160 | |
| QMB Only | | 5,803 | | | $18,544,859 | $3,196 | |
| SLMB - QI Only | | 5,404 | | | $8,757,575 | $1,621 | |
| **Grand Total** | **1,068,778** | **155,358** | **15%** | | **1,146,430,846** | **$7,379** | |

Population estimates as of July 1, 2019. Columns may not sum to total due to rounding.

Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums.

**FIGURE 10 – STANDARD MEDICAID EXPENSES – SFY 2019**

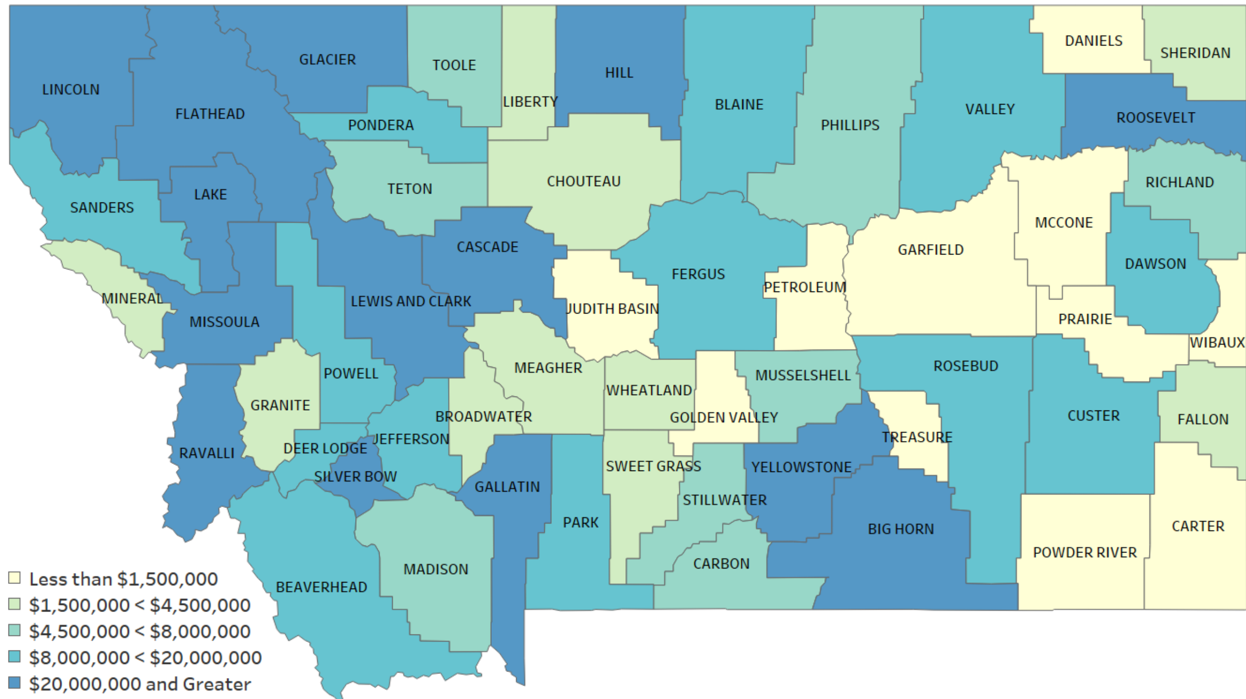



**Figure 11 – Standard Medicaid: Average Monthly Enrollment – SFY 2019**

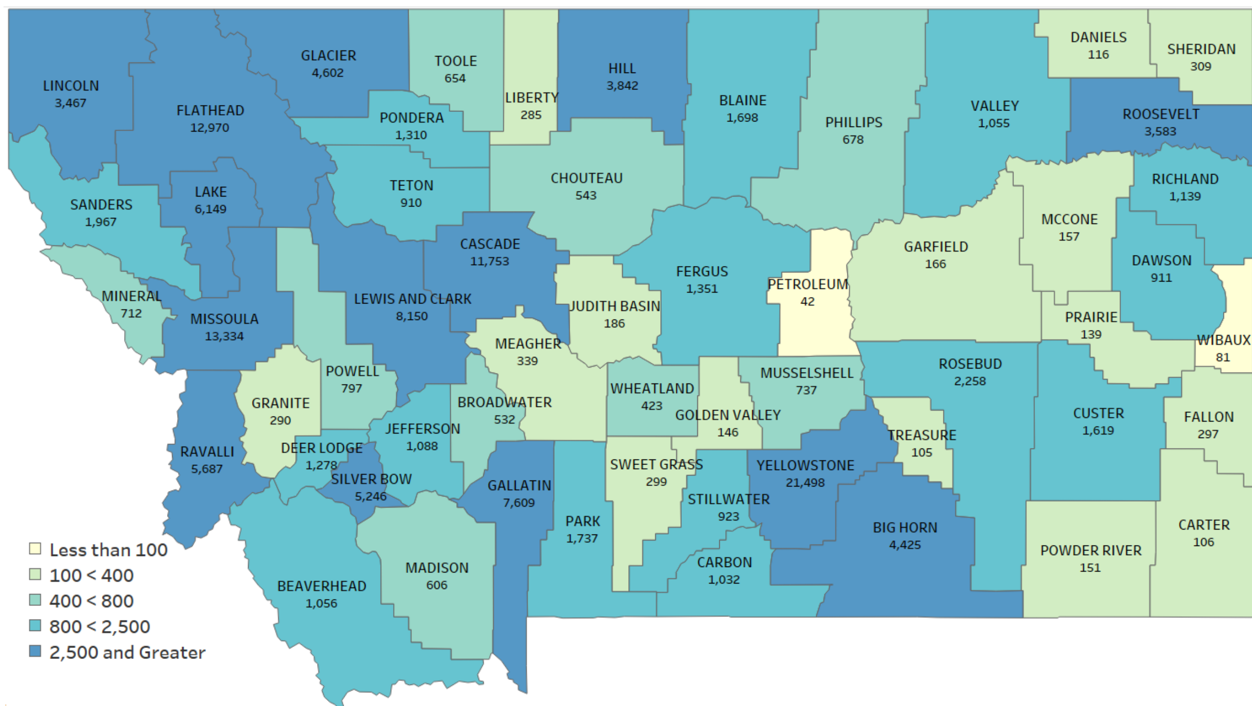


**FIGURE 12 – STANDARD MEDICAID: AVERAGE EXPENDITURE PER ENROLLEE – SFY 2019**

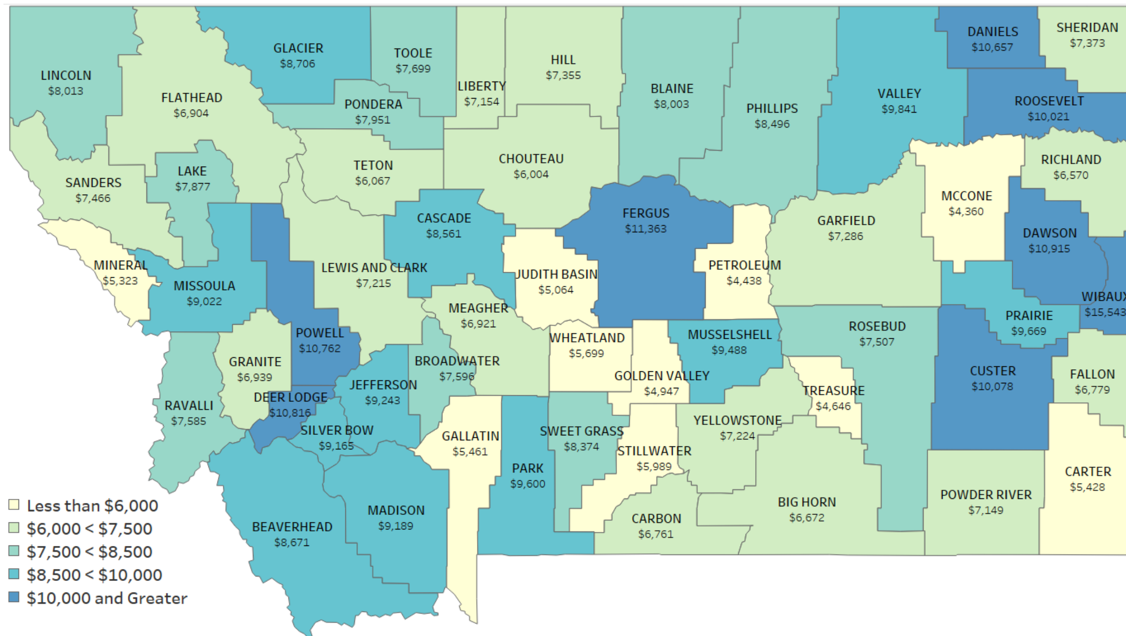
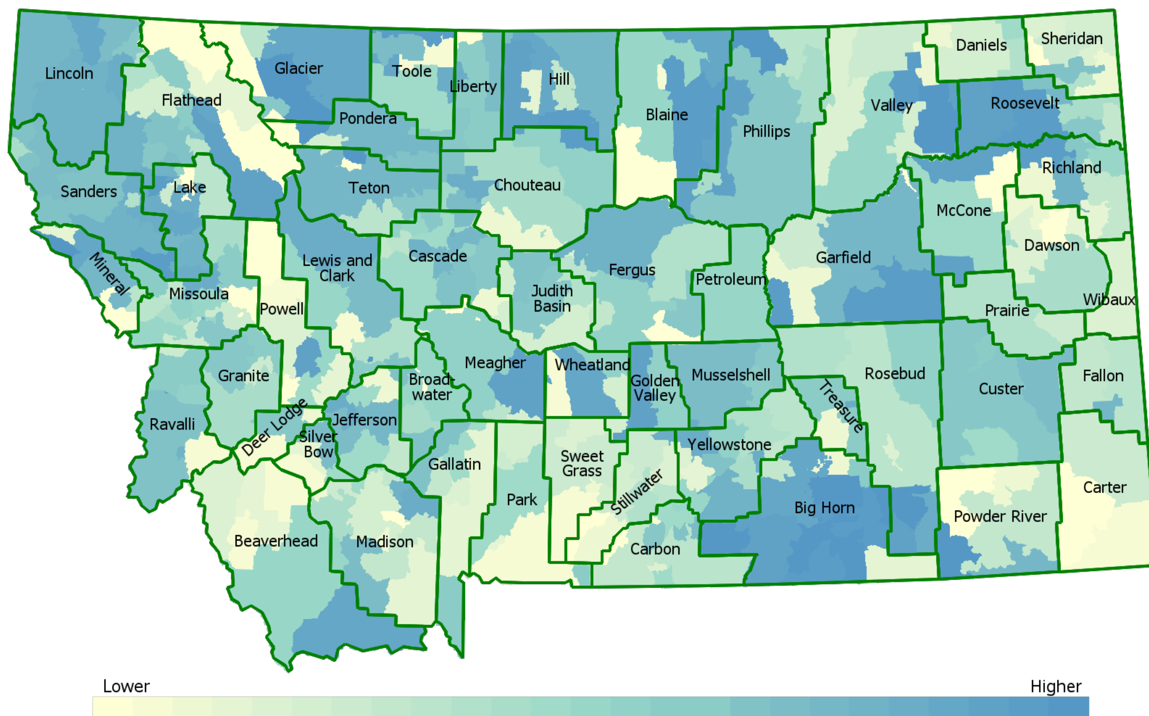



**FIGURE 13 – STANDARD MEDICAID ENROLLMENT BY PERCENT OF POPULATION**



# Montana Medicaid Benefit-related Expenditures

The following series of Medicaid expenditure data only includes benefit-related expenditures. It does *not* include administrative activity costs. Benefit-related expenditures for Hospital Utilization Fee distributions, Medicaid Buy-in, Intergovernmental Transfers (IGT), Pharmacy Rebates, Part-D Pharmacy Clawback, and Institutional Reimbursements for Medicaid, Third Party Liability (TPL), and Medically Needy offsets are included. These are non-audited expenditures on a date of service basis.

**Table 9 – Standard Medicaid Benefit Expenditures by Category**

| Categories | FY 2016 | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|---|
| Inpatient Hospital | $ 96,304,834 | $ 92,100,604 | $ 85,559,606 | $ 69,936,014 |
| Outpatient Hospital | 55,591,464 | 53,237,390 | 51,266,513 | 45,559,373 |
| Critical Access Hospital | 53,006,737 | 53,129,662 | 49,346,264 | 51,494,533 |
| Hospital Utilization Fees / DSH | 66,755,614 | 66,166,781 | 37,626,682 | 36,314,398 |
| Other Hospital and Clinical Services | 29,621,453 | 30,713,176 | 31,294,313 | 30,345,837 |
| Physician & Psychiatrists | 67,085,192 | 67,455,880 | 63,836,528 | 65,782,461 |
| Other Practitioners | 23,500,794 | 25,384,616 | 27,416,719 | 31,128,063 |
| Other Managed Care Services | 12,170,353 | 13,752,290 | 12,387,774 | 8,386,507 |
| Drugs & Part-D Clawback | 115,707,266 | 130,823,091 | 132,021,595 | 134,324,596 |
| Drug Rebates | (68,080,561) | (76,157,830) | (88,640,513) | (84,822,123) |
| Dental & Denturists | 38,420,159 | 42,302,487 | 44,425,371 | 43,564,869 |
| Durable Medical Equipment | 15,112,677 | 15,872,208 | 15,231,128 | 14,810,338 |
| Other Acute Services | 3,839,707 | 3,049,745 | 5,946,381 | 5,623,701 |
| Nursing Homes & Swing Beds | 147,378,878 | 148,621,769 | 154,722,661 | 169,414,276 |
| Nursing Home IGT | 12,527,238 | 14,150,700 | 11,255,621 | 5,590,334 |
| Community First Choice | 45,696,742 | 48,044,389 | 45,033,216 | 44,851,470 |
| Other SLTC Home Based Services | 3,600,025 | 3,706,709 | 3,693,923 | 5,670,210 |
| SLTC HCBS Waiver | 41,199,478 | 44,310,852 | 42,428,151 | 42,292,139 |
| Medicare Buy-In | 33,275,829 | 40,728,383 | 43,122,324 | 44,598,918 |
| Children's Mental Health | 94,143,937 | 94,164,480 | 92,439,100 | 87,143,157 |
| Adult Mental Health and Chem Dep | 49,725,315 | 51,253,501 | 43,952,127 | 42,807,948 |
| HIFA Waiver | 18,378,211 | 7,116,553 | 6,931,491 | 6,907,367 |
| Disability Services Waiver | 111,784,498 | 119,291,987 | 118,855,521 | 125,809,736 |
| Indian Health Service - 100% Fed funds | 52,678,768 | 59,976,334 | 63,106,740 | 73,043,302 |
| School Based Services - 100% Fed funds | 36,251,879 | 37,816,975 | 39,435,725 | 40,330,406 |
| MDC & ICF Facilities - 100% Fed funds | 11,512,162 | 9,074,285 | 7,842,317 | 5,523,016 |
| Total | $ 1,167,188,648 | $ 1,196,087,017 | $ 1,140,537,278 | $ 1,146,430,846 |

**Figure 14 – Standard Medicaid Benefit Expenditures by Category: FY 2016 to FY 2019**

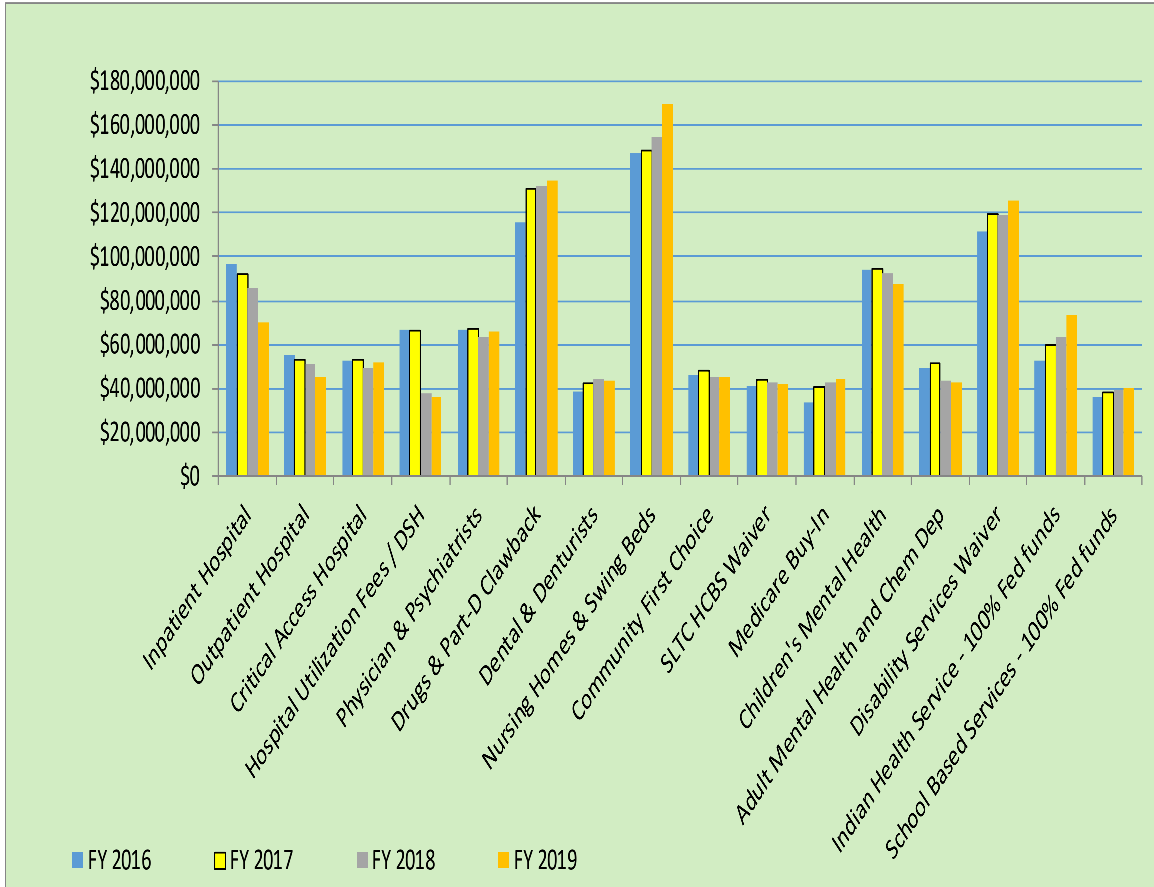


**FIGURE 15 –STANDARD MEDICAID BENEFIT EXPENDITURES SFY 2019**

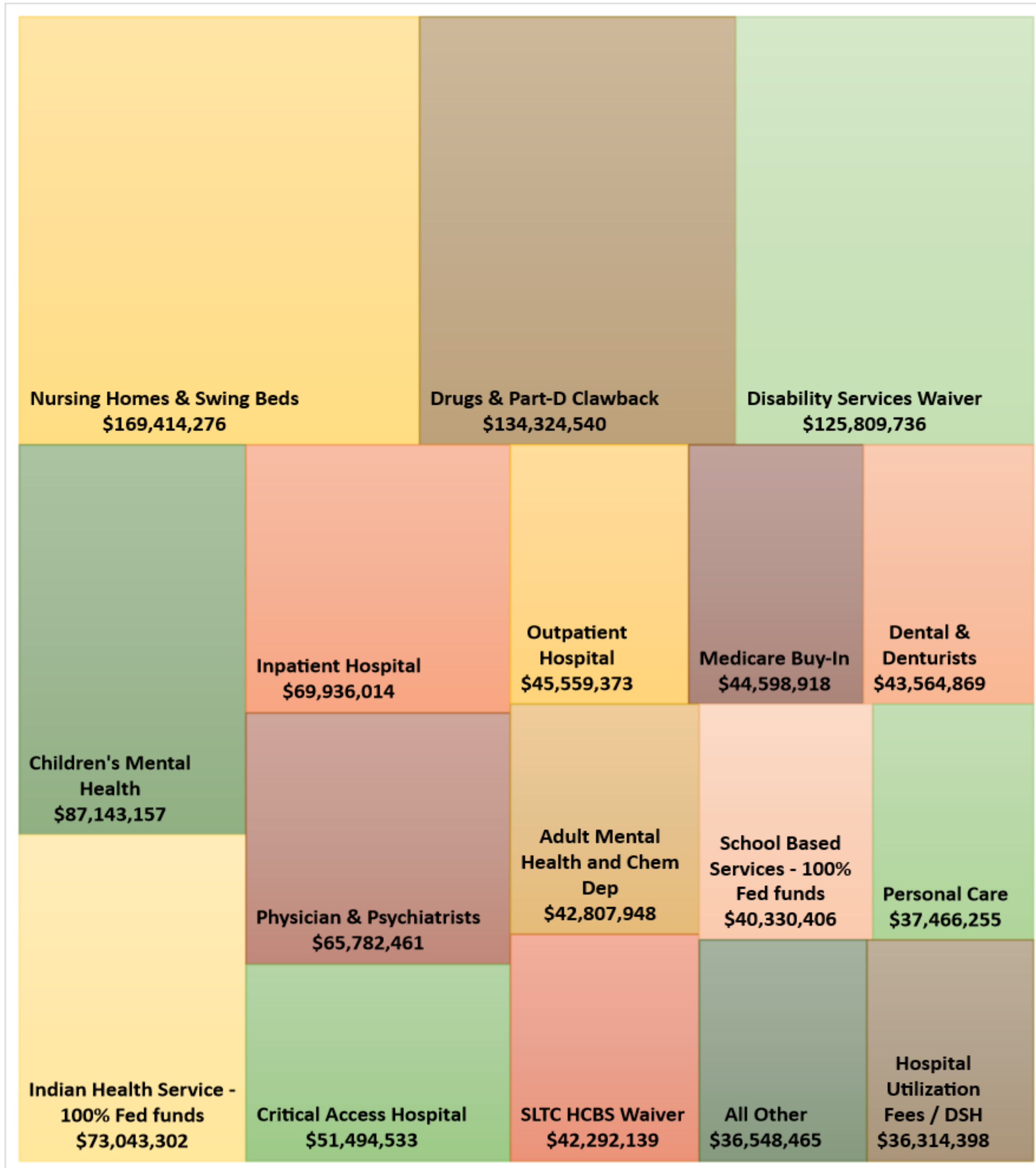
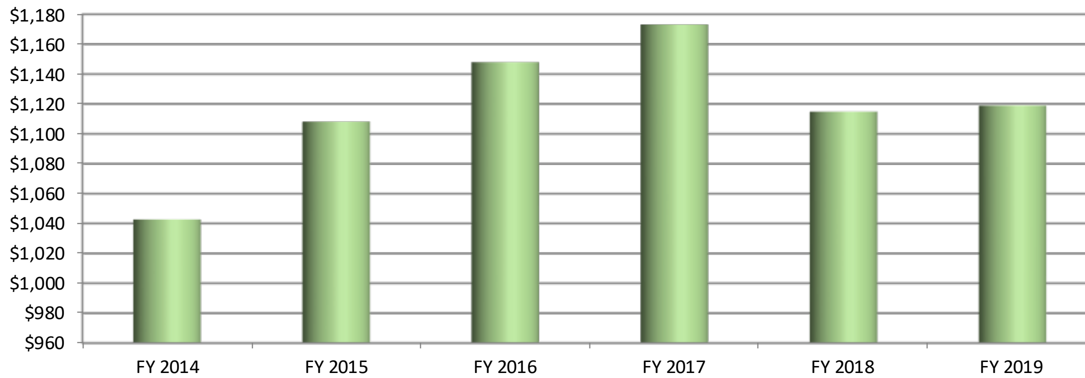
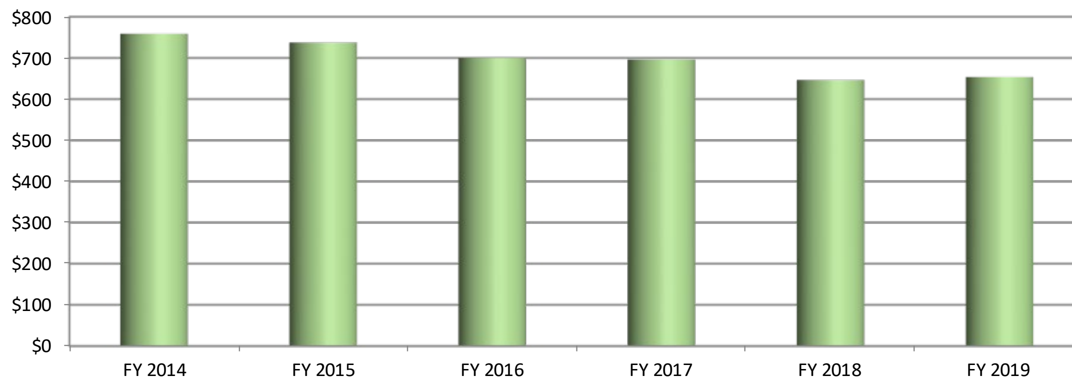
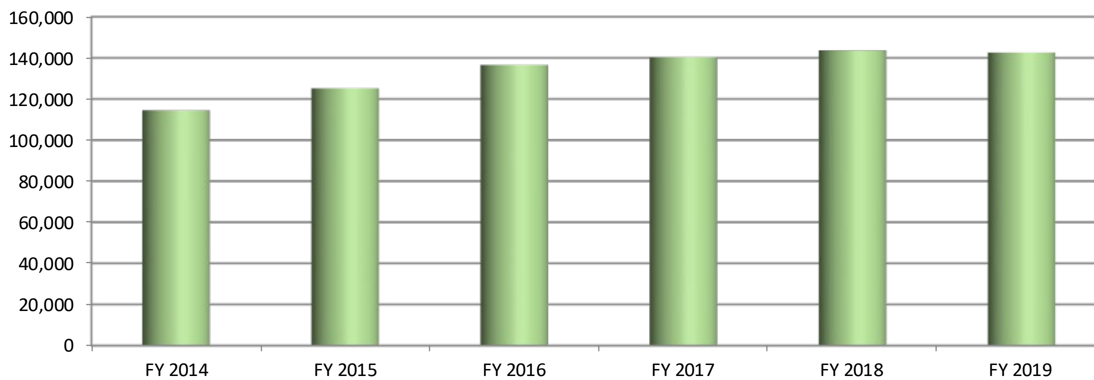


**FIGURE 16 – HISTORY OF EXPENDITURES AND ENROLLMENT**

**History of Expenditures and Enrollment**




Enrollment and expenditures exclude administrative costs, Medicare Savings Plan, HMK (CHIP) and State Funded Mental Health. Decline in per-member reimbursement is attributable to increased enrollment of low cost children.

The following charts and tables show the average monthly per-member reimbursement for various age groups and Medicaid eligibility categories. This calculation merges claims and eligibility data, ensuring client enrollment and reimbursement are counted in the same category and the updated enrollment information takes precedence over the claim information. Graphs do not include HMK (CHIP), Medicare Savings Plan, or Plan First Waiver clients and expenditures.

**Table 10 – Standard Medicaid Average per Month Enrollment**

| | | State Fiscal Year | | | | | |
|---|---|---|---|---|---|---|---|
| Age | Category | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
| < 1 | Blind/Disabled | 32 | 34 | 34 | 41 | 47 | 38 |
| < 1 | Child | 6,241 | 6,584 | 6,984 | 7,012 | 6,599 | 6,236 |
| 1 to 5 | Blind/Disabled | 552 | 494 | 482 | 445 | 368 | 363 |
| 1 to 5 | Child | 25,431 | 25,760 | 27,698 | 29,144 | 30,190 | 29,633 |
| 6 to 18 | Blind/Disabled | 2,464 | 2,496 | 2,614 | 2,529 | 2,350 | 2,200 |
| 6 to 18 | Child | 40,421 | 44,174 | 50,102 | 55,037 | 60,449 | 61,244 |
| 19 to 20 | Blind/Disabled | 499 | 478 | 430 | 415 | 420 | 406 |
| 19 to 20 | Adult | 981 | 1,309 | 1,369 | 1,209 | 1,261 | 1,370 |
| 21 to 64 | Blind/Disabled | 16,628 | 16,372 | 16,011 | 15,407 | 15,185 | 14,895 |
| 21 to 64 | Adult | 14,024 | 20,183 | 23,099 | 21,184 | 18,696 | 17,981 |
| 65 + | Aged | 7,002 | 7,033 | 7,343 | 7,585 | 7,674 | 7,812 |
| 65 + | Blind/Disabled | 229 | 289 | 367 | 388 | 437 | 445 |
| **Total** | | **114,502** | **125,207** | **136,534** | **140,396** | **143,679** | **142,623** |
| All | Plan First | 2,837 | 2,259 | 2,370 | 1,884 | 1,637 | 1,528 |
| All | QMB | 4,765 | 4,911 | 4,793 | 5,203 | 5,640 | 5,803 |
| All | SLMB - QI | 4,216 | 4,421 | 4,755 | 5,064 | 5,270 | 5,404 |
| **Total** | **All Medicaid** | **126,321** | **136,798** | **148,452** | **152,546** | **156,225** | **155,358** |
| 6 to 18 | HK Med Plus | 8,601 | 8,314 | 7,415 | 7,215 | 5,590 | 5,253 |
| **Total** | **All Categories** | **134,922** | **145,113** | **155,867** | **159,761** | **161,816** | **160,611** |

Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

**Table 11 – Standard Medicaid Monthly Reimbursement – Per Member**

| | | State Fiscal Year | | | | | |
|---|---|---|---|---|---|---|---|
| Age | Category | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
| < 1 | Blind/Disabled | $5,051 | $5,685 | $4,789 | $7,519 | $10,707 | $3,780 |
| < 1 | Child | $776 | $711 | $714 | $848 | $737 | $674 |
| 1 to 5 | Blind/Disabled | $1,697 | $1,771 | $1,827 | $1,800 | $2,060 | $2,413 |
| 1 to 5 | Child | $167 | $184 | $185 | $187 | $187 | $191 |
| 6 to 18 | Blind/Disabled | $2,143 | $2,156 | $2,148 | $2,123 | $2,066 | $2,176 |
| 6 to 18 | Child | $341 | $350 | $344 | $340 | $323 | $326 |
| 19 to 20 | Blind/Disabled | $1,576 | $1,399 | $1,425 | $1,404 | $1,364 | $1,429 |
| 19 to 20 | Adult | $706 | $625 | $621 | $526 | $390 | $398 |
| 21 to 64 | Blind/Disabled | $1,807 | $1,862 | $1,840 | $1,906 | $1,822 | $1,869 |
| 21 to 64 | Adult | $656 | $589 | $560 | $558 | $482 | $479 |
| 65 + | Aged | $2,375 | $2,391 | $2,362 | $2,381 | $2,383 | $2,472 |
| 65 + | Blind/Disabled | $1,194 | $1,167 | $1,313 | $1,739 | $1,646 | $1,580 |
| **Total** | | **$759** | **$738** | **$701** | **$696** | **$647** | **$654** |
| All | Plan First | $35 | $30 | $26 | $19 | $15 | $13 |
| All | QMB | $219 | $218 | $224 | $239 | $253 | $266 |
| All | SLMB - QI | $105 | $101 | $98 | $125 | $130 | $135 |
| **Total** | **All Medicaid** | **$700** | **$687** | **$655** | **$653** | **$608** | **$615** |
| 6 to 18 | HK Med Plus | $206 | $209 | $222 | $222 | $187 | $238 |
| **Total** | **All Categories** | **$668** | **$659** | **$635** | **$634** | **$594** | **$603** |

For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

### Table 12 – Standard Medicaid Reimbursement Totals – All Demographic Groups

| | | State Fiscal Year | | | | | |
|---|---|---|---|---|---|---|---|
| **Age** | **Category** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** |
| < 1 | Blind/Disabled | $1,939,520 | $2,296,848 | $1,953,996 | $3,661,538 | $6,092,021 | $1,701,184 |
| < 1 | Child | $58,116,427 | $56,199,723 | $59,814,245 | $71,355,615 | $58,356,744 | $50,407,241 |
| 1 to 5 | Blind/Disabled | $11,233,100 | $10,496,670 | $10,565,046 | $9,605,738 | $9,105,671 | $10,505,393 |
| 1 to 5 | Child | $51,105,327 | $57,016,043 | $61,331,877 | $65,467,168 | $67,785,981 | $67,998,367 |
| 6 to 18 | Blind/Disabled | $63,375,049 | $64,575,645 | $67,369,997 | $64,419,586 | $58,244,568 | $57,448,116 |
| 6 to 18 | Child | $165,495,330 | $185,445,550 | $206,774,450 | $224,780,060 | $234,297,596 | $239,757,868 |
| 19 to 20 | Blind/Disabled | $9,440,566 | $8,021,256 | $7,342,447 | $6,993,159 | $6,882,072 | $6,967,496 |
| 19 to 20 | Adult | $8,308,999 | $9,821,393 | $10,200,550 | $7,628,150 | $5,896,138 | $6,544,903 |
| 21 to 64 | Blind/Disabled | $360,578,047 | $365,887,574 | $353,516,713 | $352,454,551 | $332,017,122 | $334,149,115 |
| 21 to 64 | Adult | $110,320,508 | $142,610,764 | $155,192,492 | $141,920,113 | $108,120,184 | $103,285,149 |
| 65 + | Aged | $199,520,800 | $201,781,637 | $208,101,984 | $216,747,885 | $219,430,124 | $231,675,743 |
| 65 + | Blind/Disabled | $3,277,521 | $4,049,280 | $5,787,665 | $8,103,248 | $8,633,590 | $8,442,800 |
| **Total** | | **$1,042,711,194** | **$1,108,202,382** | **$1,147,951,463** | **$1,173,136,809** | **$1,114,861,812** | **$1,118,883,376** |
| All | Plan First | $1,207,390 | $804,178 | $744,926 | $436,856 | $301,095 | $245,035 |
| All | QMB | $12,545,859 | $12,824,495 | $12,873,905 | $14,908,081 | $17,156,806 | $18,544,859 |
| All | SLMB - QI | $5,294,396 | $5,336,610 | $5,618,354 | $7,605,272 | $8,217,565 | $8,757,575 |
| **Total** | **All Medicaid** | **$1,060,551,450** | **$1,127,167,665** | **$1,167,188,648** | **$1,196,087,017** | **$1,140,537,278** | **$1,146,430,846** |
| 6 to 18 | HK Med Plus | $21,264,963 | $20,865,424 | $19,783,412 | $19,223,864 | $12,520,072 | $14,997,812 |
| **Total** | **All Categories** | **$1,081,816,413** | **$1,148,033,088** | **$1,186,972,060** | **$1,215,310,881** | **$1,153,057,350** | **$1,161,428,658** |

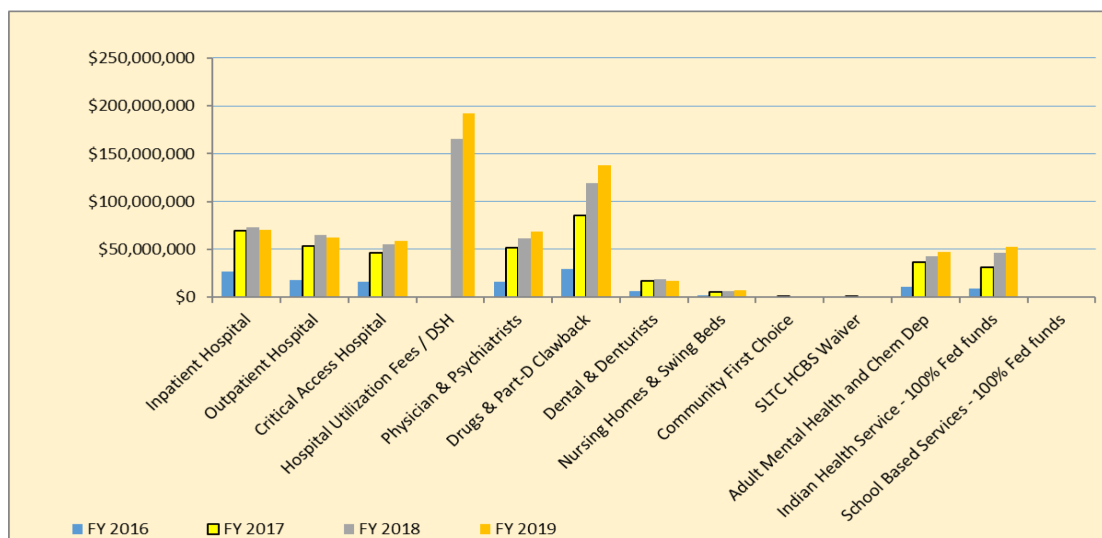
Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

# Medicaid Expansion Enrollment and Expenditures

### Table 13 - Medicaid Expansion Benefit Expenditures by Category

| Categories | FY 2016 | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|---|
| Inpatient Hospital | $ 26,925,948 | $ 69,719,422 | $ 72,660,577 | $ 70,139,123 |
| Outpatient Hospital | 17,647,206 | 53,168,458 | 64,963,446 | 62,295,276 |
| Critical Access Hospital | 15,911,263 | 46,360,952 | 55,542,635 | 58,449,963 |
| Hospital Utilization Fees / DSH | - | - | 165,320,035 | 192,266,844 |
| Other Hospital and Clinical Services | 8,492,063 | 24,116,004 | 40,084,612 | 42,934,490 |
| Physician & Psychiatrists | 16,301,364 | 51,899,551 | 61,937,606 | 68,978,621 |
| Other Practitioners | 4,254,975 | 15,307,002 | 21,975,883 | 24,797,371 |
| Other Managed Care Services | 888,889 | 4,253,624 | 5,875,492 | 4,805,434 |
| Drugs & Part-D Clawback | 29,375,828 | 85,455,966 | 118,921,819 | 138,261,633 |
| Drug Rebates | (12,047,718) | (43,581,114) | (65,516,327) | (94,063,309) |
| Dental & Denturists | 6,001,760 | 17,183,515 | 18,874,345 | 17,012,660 |
| Durable Medical Equipment | 1,526,967 | 5,326,433 | 5,818,145 | 6,025,455 |
| Other Acute Services | 1,250,962 | 5,640,374 | 11,946,422 | 13,436,026 |
| Nursing Homes & Swing Beds | 1,669,312 | 5,107,674 | 6,239,474 | 6,917,750 |
| Community First Choice | 273,118 | 882,396 | 1,182,020 | 1,399,188 |
| Other SLTC Home Based Services | 463,823 | 1,178,236 | 1,278,323 | 1,234,375 |
| SLTC HCBS Waiver | 967 | 1,458 | 36,671 | 32,758 |
| Adult Mental Health and Chem Dep | 10,628,023 | 37,004,957 | 42,731,584 | 47,112,574 |
| Indian Health Service - 100% Fed funds | 9,424,453 | 31,289,905 | 46,468,706 | 52,842,364 |
| School Based Services - 100% Fed funds | - | - | - | 16,648 |
| MDC & ICF Facilities - 100% Fed funds | - | - | 211,727 | 179,394 |
| Total | $ 138,989,200 | $ 410,314,812 | $ 676,553,194 | $ 715,074,638 |

### Figure 17 –Medicaid Expansion Benefit Expenditures by Category: FY 2016 to FY 2019



## Providers

Medicaid provides services through a network of private and public providers, including clinics, hospitals, nursing facilities, physicians, nurse practitioners, physician assistants, community health centers, tribal health, and the Indian Health Service (IHS). Montana Medicaid providers predominately live and work in communities across the state and serve as major employers. In SFY 2017, Medicaid service providers received reimbursements, resulting in over $1 billion flowing into Montana's economy.

Examples of services offered by providers (either directly or indirectly) include:

- Primary care
- Preventive care
- Health maintenance
- Treatment of illness and injury
- Coordinating access to specialty care
- Providing or arranging for child checkups; children's healthcare (EPSDT)services, lead screenings, and immunizations

For more information, please refer to:

Montana Healthcare Programs Provider Information

DPHHS Provider Search

# Claims Processing

DPHHS currently contracts with Conduent to process claims for reimbursement. Conduent meets the rigorous requirements established by CMS to be a Medicaid fiscal agent.

**TABLE 13 – COMPARISON OF PAPER AND ELECTRONIC CLAIMS PROCESSED (2019)**

| Claim Type | Number Processed | Percentage of Total |
|---|---|---|
| Paper | 562,430 | 4% |
| Electronic | 13,498,332 | 96% |
| Total | 14,060,762 | 100% |

DPHHS is working to replace the State's aging legacy Medicaid Management Information System (MMIS). The Montana Program for Automating and Transforming Healthcare (MPATH) will support the receipt, adjudication, editing, pricing, and payment of health care claims. The configurable module will also process service authorizations, third-party insurance liability, and calculate member liabilities (including cost share and cost share coordination) between multiple payers.

# Payment Methodologies

The Montana Medicaid Program payment rate methodologies include:

**Reimbursement Systems for Hospitals** – Determines provider pay rates by examining cost, utilization, relative value, etc. Consists of the following reimbursement systems:

- **All Patient Refined-Diagnosis Related Grouper (APR-DRG) Charge Cap(APR-DRG)** system – Establishes payment rates for inpatient services at certain hospitals
- Ambulatory Payment Classification – Establishes outpatient payment rates
- Cost-based reimbursement for Critical Access Hospitals (CAH) – Limited service hospitals designed to provide essential services to rural communities

**Resource Based Relative Value System (RBRVS)**

- Reimburses physicians and other providers who bill on CMS-1500 forms with an adaption of Medicare's RBRVS
- System developed by CMS, the American Medical Association (AMA), and non-physician provider associations
- Determines reimbursement based on service value, relative to other services
- Benefits Montana with ongoing investment in research and policy-making, without yielding control of costs; rate is adjusted annually

**Rate + Quality System**

- Two component rate methodology – Flat rate with a quality rate component.
- The Flat Rate Component is the same per diem rate for all nursing facilities and is set or adjusted through a public ARM process.
- The Quality Component is based on 5-Star rating system for nursing facility services calculated by the Centers for Medicare/Medicaid Services. It is set for each facility based on their average 5-star ratings for staffing and quality. Facilities with an average of 3-5 stars receive a quality component payment.

**Fee-for-Service** – Fees established for specific products/services

- Pharmacy services are one of the major services reimbursed
- Pharmacies receive a professional dispensing fee for each prescription, plus the cost of the ingredient

# Medicaid Cost Containment Measures

Medicaid containment measures reduce costs and improve the efficiency of the program:

**Healthy Outcome Initiatives**
- Early/Elective Inductions and Cesarean Sections
- Long Acting Reversible Contraceptives
- Promising Pregnancy Care (PPC)
- School Based Services

**Physician/Mid-Level Practitioner**
- Nurse Advice Line
- Team Care
- Passport to Health
- Comprehensive Primary Care Plus (CPC+)

**Hospital**
- Out-of-State Inpatient Hospitals
- All Patient Refined-Diagnosis Related Grouper (APR-DRG) Charge Cap

**Transportation**

**Eyeglasses**

**Pharmacy**
- Prior Authorization
- Drug Utilization Review
- Over-the-Counter Drug Coverage
- Mandatory Generic Substitution
- Dispensing Restrictions
- Preferred Drug List and Supplemental Rebates
- Drug Rebate Collection
- Average Acquisition Cost (AAC**)**
- HMK **and Pharmacy Processed through MMIS**

**Long-Term Care**
- Tribal Nursing Facility Rates
- Money **Follows the Person (MFP)**
- Community First Choice (CFC)
- Long Term Care Insurance
- Prior Authorization
- Intergovernmental Fund Transfer
- Nursing Facility Transitions

**Third Party Liability**
- Medicare Buy-In and Medicare Savings Program

# Health Outcome Initiatives

## Early/Elective Inductions and Cesarean Sections

- Reduces reimbursement for non-medically necessary inductions, prior to 39 weeks
- Reduces reimbursements for non-medically necessary cesarean deliveries at any gestational age

**Long Acting Reversible Contraceptives (LARC)**

- Allows hospitals to bill separately for LARC, inserted at the time of delivery
- Reduces unplanned pregnancies

## Promising Pregnancy Care (PPC)

- Consists of 10 group-driven classroom sessions; improves pregnancy knowledge, readiness for labor, satisfaction with care, and breastfeeding initiation rates
- Reduces deliveries of pre-term infants

## Lactation Services

- Provides reimbursement for lactation services in outpatient hospitals
- Provides participants with access to a prenatal lactation group class and post-natal one-on-one lactation consultations

## School Based Services

- Provides federal Medicaid match for services previously provided by school districts
- Allows children to receive additional needed services such as mental health care and speech therapy at no additional cost to the school district
- Office of Public Instruction certifies fund matching for Medicaid reimbursed services, as part of each participating child's Individualized Education Plan

**Physician/Mid-Level Practitioner**

## Nurse Advice Line

- Provides toll free, confidential advice line to all Medicaid and HMK Plus members

- Registered nurses triage caller symptoms and guide callers to obtain care in appropriate settings (self-care, physician, or urgent or emergent care)

### Team Care

- Medicaid members with a history of over-utilizing Medicaid services are required to participate (program currently has approximately 650 participants)
- Team Care members are managed by a team consisting of a Passport to Health primary care provider, one pharmacy, the Nurse Advice Line, and DPHHS staff

### Passport to Health

- Primary Case Management Program was implemented to reduce medical costs and improves quality of care
- Members choose primary care provider, who performs/provides referrals for care

### Patient-Centered Medical Home

- Provides Medicaid and HMK Plus members with comprehensive, coordinated approach to primary care
- Primary care providers (PCPs) receive additional reimbursement for each member enrolled for providing enhanced services, reporting quality measures, and supporting comprehensive infrastructure

### Comprehensive Primary Care Plus (CPC+)

- Provides practices with a robust learning system and actionable patient-level cost and utilization data feedback, to guide their decision making
- Results in better delivery of medical care and healthier population

## Hospital

### Out-of-State Inpatient Hospitals

- Requires prior authorization for all inpatient hospital services out-of-state
- Promotes utilization of available health resources in-state

### All Patient Refined-Diagnosis Related Grouper (APR-DRG) Charge Cap

- Reimburses hospitals in the APR-DRG system the lesser of billed charges, or APR-DRG rate

## Transportation

- Provides assistance with obtaining medically necessary transportation services (requires prior authorization)

## Eyeglasses

- Reduces eyeglass cost significantly through bulk contract purchasing

## Pharmacy

### Prior Authorization (PA)

- Requires mandatory advance approval of certain medications before they are dispensed, for any medically accepted indication
- Process is handled either at the Drug PA unit or through the pharmacy claims processing program

### Drug Utilization Review

- Prospective and retrospective review of drug use to ensure proper utilization

### Over-the-Counter Drug Coverage

- Provides cost-effective alternative to higher-priced federal legend drugs (when prescribed by a physician)

### Mandatory Generic Substitution

- Requires pharmacies to dispense generic forms of prescribed drugs

### Dispensing Restrictions

- Restricts quantities per prescription and number of refills

### Preferred Drug List and Supplemental Rebates

- Medicaid’s Drug Utilization Review Board/Formulary Committee selects drugs in various classes of medications
- Extensive review of medications yields best value to Medicaid program, including increased supplemental rebates

### Drug Rebate Collection

- Dedicated staff review rebate programs and conduct claim/invoice audits, prior to invoicing pharmaceutical manufacturers
- Reduces disputes with manufacturers, resulting in more timely payment

- Drug rebates constitute over 65% of Medicaid pharmacy expenditures ($94 million in FY 2019)

**Average Acquisition Cost (AAC)**

- Replaces the estimated acquisition cost reimbursement methodology; now sets drug ingredient reimbursement as close to actual acquisition as possible
- Bases acquisition cost on drug invoice data collected from wholesalers and Montana pharmacy providers

**HMK and Pharmacy Processed through MMIS**

- Provides consistent prescription drug formulary for children who change eligibility between HMK Plus and HMK
- Results in continuity of care and decreased drug changes

## Long-Term Care

**Tribal Nursing Facility Rates**

- DPHHS renegotiated payment rate with the Crow and Blackfeet Tribes, substantially increasing reimbursement for tribally-owned nursing facilities
- Majority of tribal nursing home patients became eligible for 100% federal match
- Annual savings of $1 million/year to each Tribe; savings of $600,000/year to state

**Money Follows the Person (MFP)**

- CMS-awarded demonstration grant helps pay for services to people who already receive Medicaid funded care in an institutional setting and wish to move into certain types of community settings
- Targets persons in the Montana Developmental Center transitioning to the community; persons with complex needs (including traumatic brain injury), Severe Disabling Mental Illness (SDMI), physical disabilities, and/or elders in nursing homes; and individuals aged 18-21 in the Montana State Hospital
- All waiver and demonstration services receive an enhanced Federal Medical Assistance Percentage (FMAP) rate for Medicaid benefits for a period of 365 days of service; at day 366, a participant is served under a HCBS waiver at regular FMAP
- Grant funding will continue through the Q1 of calendar year 2019

**Community First Choice (CFC)**

- Covers home and community-based attendant services and supports to assist members with activities of daily living, instrumental activities of daily living, health-related related tasks, and related support services
- Incentivizes with a permanent 6% increase in the federal share of Medicaid's cost (the FMAP rate) for CFC services

**Long Term Care Insurance**

- Helps defray Medicaid costs (once partnership policies are utilized)
- An institutionalized/waiver individual or spouse who purchased a Qualified Long Term Care Partnership (LTC) policy or converted a previously-existing LTC policy to a Qualified LTC Partnership policy on or after July 1, 2009 may protect resources equal to the insurance benefits received from the policy.
- Asset protection through LTC Partnership is available only after Qualified LTC Partnership policy lifetime limits have fully exhausted LTC services for the Medicaid applicant or spouse. The amount of assets protected will be equal to the insurance benefits paid

**Prior Authorization** – Prior authorization for most community-based services

**Intergovernmental Fund Transfer**

- Participating counties pay a fee that is matched with federal funds, which are redistributed to at-risk nursing facilities
- Important component of nursing home reimbursement

**Nursing Facility Transitions**

- Helps provide services in the least-restrictive setting to nursing facility residents transitioning into community
- Dollars for services (money-follows-the-person) approach helps to rebalance long term care system; reduces costs
- In SFY 2017, the program helped transition into the community 37 nursing facility residents, who were also on the HCBS Big Sky Waiver wait list

## Third Party Liability (TPL)

- Identifies third parties liable for payment of Medicaid member medical costs (Medicare, private health insurance, auto accident policies, and workers' compensation)
- Includes recovery for payments made for certain long-term services from the estates of members who have passed away
- In SFY17, Montana cost avoided $195.9 million in Medicaid payments

**Medicare Buy-In and Medicare Savings Program**

- Medicare Buy-In designates Medicare the primary payer for Medicare and Medicaid "full" dual eligible recipients, resulting in major cost savings
- Medicare Part-B premiums are paid directly to CMS for certain recipients
- Medicare Part-A premiums are paid for Medicaid enrollees receiving Supplemental Security Income SSI payments, who become entitled to Medicare at age 65
- Medicare Savings Program provides Medicare Buy-in benefits to people with Medicare who are not eligible for full Medicaid services, but have limited income and assets:
  - Qualified Medicare Beneficiary (QMB) – Covers both Medicare Part A and B premiums and some co-payments and deductibles
  - Specified Low Medicare Beneficiary (SLMB) – Covers Medicare Part-B premium only
  - Qualified Individual (QI-1) – Covers Medicare Part-B premium through 100% federal dollars

  All three categories automatically entitle the enrollee to Low Income Subsidy (LIS) or "Extra Help" status for the Medicare Prescription Drug Plan (Part-D).
- Due to the cost efficiency of having Medicare as the first payer, a concerted effort is ongoing to ensure that anyone meeting the eligibility criteria is enrolled.

For more information, please refer to:

https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs

# Program and Payment Integrity Activities

- Medicaid Management Information System (MMIS) scans for fraud and billing errors and stops payment when irregularities are detected
- Medicaid coordinates with efforts to identify, recover and prevent inappropriate provider billings and payments.
- Two state programs help protect the state Medicaid program:
  - DPHHS Quality Assurance Division – Responsible for insuring proper payment and recovering misspent funds
  - Attorney General's Medicaid Fraud Control Unit (MFCU) – Responsible for investigating and ensuring prosecution of Medicaid fraud
- At the federal level, CMS and the Office of Inspector General (OIG) of the Department of Health and Human Services oversee state program and payment integrity activities
- Two federal audit contractors:
  - PERM operates on a cycle, evaluating states every 3 years. Montana's PERM cycle reviewed claims from FFY2017. Results are pending from CMS
  - Montana currently has a waiver from CMS for the requirement to have a RAC. We are in the process of looking for a contractor.
- Results of Medicaid Cost Containment Measures:
  - Clarification/streamlining of Medicaid policies, rules, and billing procedures
  - Increased payment integrity, recovery of inappropriately billed payments, and avoidance of future losses
  - Education of providers, regarding proper billing practices
  - Termination of some providers from participation in the Medicaid program
  - Referrals to the Attorney General's Medicaid Fraud Control Unit (MFCU)

## State and Federal Shares

Medicaid services are funded by a combination of federal, state, and (in some cases) local funds. The federal match rate, for most Medicaid services provided to Montanan's eligible for the standard benefit plan, is derived by comparing the state average per capita income to the national average. For example, in State Fiscal Year 2019, for every Medicaid dollar, the federal share was 65.47 cents, and the Montana state share was 34.53 cents.

**TABLE 14 – MONTANA MEDICAID BENEFITS – FEDERAL/STATE MATCHING RATE**

| State Fiscal Year | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|
| Federal Match Rate | 65.36% | 65.50% | 65.42% | 65.47% | 64.95% | 65.43% | 65.01% | 64.90% |
| State Match Rate | 34.64% | 34.50% | 34.58% | 34.53% | 35.05% | 34.57% | 34.99% | 35.10% |

The chart below details the amount of matching federal dollars for each state dollar spent on traditional Medicaid benefits, as determined by the Federal Medical Assistance Percentage (FMAP).

This rate was temporarily increased

1) during the recession period 2009-2012, as part of the American Recovery and Reinvestment Act (ARRA), and
2) during the COVID19 Public Health Emergency 2020-2021.

**FIGURE 18 – TRADITIONAL MEDICAID – FEDERAL DOLLAR MATCHING SHARE – SFY 2006-2023**

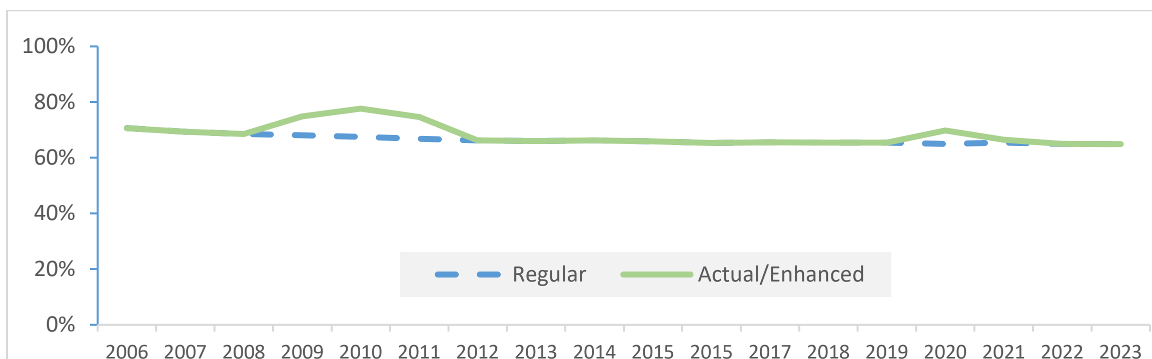


**Table 15 – Traditional Medicaid – Comparison of Regular vs. Actual/Enhanced Dollar Match**

| State Fiscal Year | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|
| Regular | 70.66% | 69.29% | 68.59% | 68.08% | 67.48% | 66.86% | 66.21% | 66.04% | 66.25% |
| Actual/Enhanced | 70.66% | 69.29% | 68.59% | 74.80% | 77.65% | 74.58% | 66.21% | 66.04% | 66.25% |
| State Fiscal Year | 2015 | 2015 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Regular | 65.92% | 65.36% | 65.50% | 65.42% | 65.47% | 64.95% | 65.43% | 65.01% | 64.90% |
| Actual/Enhanced | 65.92% | 65.36% | 65.50% | 65.42% | 65.47% | 69.80% | 66.43% | 65.01% | 64.90% |

The final 6 months of SFY 2020 and the first 9 months of SFY 2021 received the Enhanced FMAP noted in Table 17.

# Glossary

**All Patient Refined Diagnosis Related Group (APR-DRG)** – The Diagnosis Related Groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. There are currently three major versions of the DRG in use: basic DRGs, All Patient DRGs, and All Patient Refined DRGs. The basic DRGs are used by the Centers for Medicare and Medicaid Services (CMS) for hospital payment for Medicare beneficiaries. The All Patient DRGs (AP-DRGs) are an expansion of the basic DRGs to be more representative of non-Medicare populations such as pediatric patients. The All Patient Refined DRGs (APR-DRG) incorporate severity of illness subclasses into the AP-DRGs.

**Ambulatory Surgical Centers (ASC)** – ASCs, also known as outpatient surgery centers or same day surgery centers, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization.

**Care Managers** – Care managers are employees of insurance companies who review and approve or disapprove procedures or surgeries before they occur. Decisions of the care managers are meant to control costs for the insurance company and alert consumers that a particular procedure will or will not be covered by their health insurance plans

**Categorically Needy** – Refers to an individual with an attribute (disability, pregnant, child, etc.) for which there is a mandatory or optional Medicaid program

**Centers for Medicare and Medicaid Services (CMS)** – CMS is part of the federal Department of Health and Human Services (HHS). CMS oversees the following programs: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. Part of this agency's responsibilities includes monitoring health outcomes and cost control in health insurance funded by the federal government.

**Comparability** – 1902(a)(10)(B) — A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees. Waivers of comparability allow states to limit an enhanced benefit package to a targeted group of persons identified as needing it most and to limit the number of participants to implement a demonstration on a smaller scale.

**Critical Access Hospitals (CAH)** – Limited service hospitals designed to provide essential services to rural communities

**Fee-for-Service** – A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

**Freedom of choice** – 1902(a)(23) — All beneficiaries must be permitted to choose a health care provider from among any of those participating in Medicaid. Freedom of choice waivers are typically used to allow implementation of managed care programs or better management of service delivery.

**Intermediate Care Facility (ICF)** – A residential medical facility, known in federal regulations as a nursing facility, that provides health-related services above the level of room and board, and is certified and recognized under State law as a provider of such medical services. Residents must be admitted by a physician and continuously remain under a physician's care. An ICF is licensed and monitored by DPHHS.

**Spend Down** – A process by which a person may subtract medical expenses (cost of medical care, equipment, and supplies, health insurance premiums and copayments, and prescription and over-the-counter medications) from their income to become Medicaid eligible. The Medicaid program may review an applicant's medical expenses (not paid by Medicare or other insurance) usually over a six-month period (A spouse's income and medical expenses are also calculated). The expenses are calculated whether or not the applicant has actually paid them for any given month.

**Statewideness** – 1902(a)(1) — Statute dictates that a state Medicaid program cannot exclude enrollees or providers because of where they live or work in the state. A waiver of "statewideness" can limit the geographic area in which a state is testing a new program, facilitate a phased-in implementation of a program, or reduce state expenditures by limiting eligible participants. Waivers allow states to target waivers to areas of the state where the need is greatest, or where certain types of providers are available.

Acronyms

AAC – Average Acquisition Cost

AMA – American Medical Association

AMDD – Addictive and Mental Disorders Division

APR-DRG – All Patient Refined-Diagnosis Related Grouper (APR-DRG)

CAH – Critical Access Hospitals

CAW – Children's Autism Waiver

CFC – Community First Choice

CMS – Centers for Medicare and Medicaid Services

CSCT – Comprehensive School and Community Treatment

DD – Developmental Disabilities

DPHHS – Department of Public Health and Human Services

DRG – Diagnosis Related Group

DSD – Developmental Services Division

FQHC – Federally Qualified Health Centers

FMAP – Federal Medical Assistance Percentage (the Federal reimbursement percentage for approved medical services)

FPL: Federal Poverty Level

FQHC: Federal Qualified Health Center

FY: Fiscal Year (state FY is July 1—June 30; federal FY is October 1—September 30)

HCBS: Home and Community Based Services

HIFA: Health Insurance Flexibility and Accountability

HELP Act: Health and Economic Livelihood Partnership

HMK – Healthy Montana Kids (HMK) is the largest provider of health care coverage for children in the State of Montana. HMK covers children through Medicaid and CHIP funding.

HMK Plus – The Medicaid portion of HMK is referred to as Healthy Montana Kids Plus.

IHS – Indian Health Service IGT – Inter Governmental Transfers

LARC – Long Acting Reversible Contraceptives

LTC – Qualified Long Term Care Partnership

MFCU – (Attorney General's) Medicaid Fraud Control Unit

MFP – Money Follows the Person

MMIS – Medicaid Management Information System

MWD – Montana Medicaid for Workers with Disabilities

OIG – Office of Inspector General

PA – Prior Authorization

PERM – Payment Error Rate Measurement

PCMH – Patient-Centered Medical Home

PPC – Promising Pregnancy Care

PCP – Primary Care Provider

QI – Qualifying Individual

RAC – Recovery Audit Contractors

RBRVS – Resource-Based Relative Value Scale

RHC – Rural Health Clinic

SDMI – Severe and Disabling Mental Illness

SFY – State Fiscal Year (July 1—June 30)

SLMB – Specified Low-Income Medicare Beneficiary

SMAC – State Maximum Allowable Cost

SSI – Supplemental Security Income

SPA – State Plan Amendment

TPA – Third Party Administrator

TPL – Third Party Liability

QMB – Qualified Medicare Beneficiary